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Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Teleconference Meeting
November 18, 2021
9:00 AM – 1:00 PM

Mental Health Services
Oversight & Accountability Commission

1325 J Street, Suite 1700, Sacramento, California 95814
Phone: (916) 445-8696 * Email: mhsoac@mhsoac.ca.gov
* Website: www.mhsoac.ca.gov

Commission/Teleconference Meeting Notice

NOTICE IS HEREBY GIVEN that the Mental Health Services Oversight and Accountability Commission will conduct a **teleconference meeting on November 18, 2021.**

This meeting will be conducted pursuant to Governor Newsom's Executive Order N-29-20, issued March 17, 2020, which suspended certain provisions of the Bagley-Keene Open Meeting Act during the declared State of Emergency response to the COVID-19 pandemic. Consistent with the Executive Order, in order to promote and maximize social distancing and public health and safety, this meeting will be conducted by teleconference only. The locations from which Commissioners will participate are not listed on the agenda and are not open to the public. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

DATE: November 18, 2021

TIME: 9:00 a.m. – 1:00 p.m.

ZOOM ACCESS:

FOR COMPUTER/APP USE:
Link : https://mhsoac-ca-gov.zoom.us/j/85696470994
Meeting ID: 856 9647 0994
Passcode: 0L*g6jL2

FOR DIAL-IN PHONE USE:
Dial-in Number: 1-408-638-0968
Meeting ID: 856 9647 0994
Passcode: 36912478

Public Participation: The telephone lines of members of the public who dial into the meeting will initially be muted to prevent background noise from inadvertently disrupting the meeting. Phone lines will be unmuted during all portions of the meeting that are appropriate for public comment to allow members of the public to comment. Please see additional instructions below regarding Public Participation Procedures.

***The Commission is not responsible for unforeseen technical difficulties that may occur in the audio feed.**

PUBLIC PARTICIPATION PROCEDURES: All members of the public shall have the right to offer comment at this public meeting. The Commission Chair will indicate when a portion of the meeting is to be open for public comment. **Any member of the public wishing to comment during public comment periods must do the following:**

- **If joining by call-in, press *9 on the phone.** Pressing *9 will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. **When it is your turn to comment, the meeting host will unmute your line and**

announce the last three digits of your telephone number. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

- **If joining by computer, press the raise hand icon on the control bar.** Pressing the *raise hand* will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. **When it is your turn to comment, the meeting host will unmute your line and announce your name and ask if you'd like your video on**. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.
- **Under newly signed AB 1261**, by amendment to the Bagley-Keene Open Meeting Act, members of the public who use translating technology will be given **additional time** to speak during a Public Comment period. Upon request to the Chair, they will be given at least twice the amount of time normally allotted.

Our Commitment to Excellence

The Commission's 2020-2023 Strategic Plan articulates three strategic goals:

1) Advance a shared vision for reducing the consequences of mental health needs and improving wellbeing – and promote the strategies, capacities and commitment required to realize that vision.
2) Advance data and analysis that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes; and, elevate opportunities to transform and connect programs to improve results.
3) Catalyze improvement in state policy and community practice by (1) providing information and expertise; (2) facilitating networks and collaboratives; and, (3) identifying additional opportunities for continuous improvement and transformational change.

Our Commitment to Transparency

Per the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.mhsoac.ca.gov at least 10 days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 445-8696 or by emailing mhsoac@mhsoac.ca.gov

Our Commitment to Those with Disabilities

Pursuant to the American with Disabilities Act, individuals who, because of a disability, need special assistance to participate in any Commission meeting or activities, may request assistance by calling (916) 445-8696 or by emailing mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance whenever possible.

AGENDA

Lynne Ashbeck
Chair

Mara Madrigal-Weiss
Vice Chair

Commission Meeting Agenda

All matters listed as "Action" on this agenda, may be considered for action as listed. Any item not listed may not be considered at this meeting. Items on this agenda may be considered in any order at the discretion of the Chair.

9:00 AM **Call to Order**

Chair Lynne Ashbeck will convene the Commission meeting, make announcements, and hear committee updates.

9:15 AM **Roll Call**

Roll call will be taken.

9:20 AM **General Public Comment**

General Public Comment is reserved for items not listed on the agenda. No discussion or action by the Commission will take place.

9:50 AM **Action**

1: October 28, 2021 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the October 28, 2021 teleconference meeting.

- Public Comment
- Vote

10:00 AM **Action**

2: Election of the MHSOAC Chair and Vice-Chair for 2022

- **Presenter: Maureen Reilly, Acting Chief Counsel**

Nominations for Chair and Vice-Chair for 2022 will be entertained and the Commission will vote on the nominations and elect the next Chair and Vice-Chair.

- Public Comment
- Vote

10:30 AM **Action**

3: Shasta County Innovation Plan

- **Presenter: Donnell Ewert, Director, Shasta County Health and Human Services Agency**

The Commission will consider approval of $1,750,000 in innovation spending funding for Shasta County's Hope Park Innovation Project.

- Public Comment
- Vote

11:10 AM **BREAK**

11:20 AM **Action**

4: Alameda County Innovation Plan

- **Presenter: Yolanda Takahashi, Emergency Medical Services Coordinator, CATT Project Manager**

The Commission will consider augmenting the Community Assessment Transportation Team (CATT) Innovation Project for an additional $4,759,312 in Innovation spending authority. The augmentation would bring the total authorized Innovation expenditure for this project to $14,637,394 over five years. The original Innovation project was approved by the Commission on October 25, 2018, for $9,878,082 over five years.

- Public Comment
- Vote

12:00 PM **Action**

<u>5: Anti-Bullying Project Outline and Authority to Execute Contracts</u>

Presenters:

- **Anna Naify, Consulting Psychologist**
- **Miriam Bookey, Partner & Founder, Program11**

The Commission will hear recommendations from the Anti-Bullying Advisory Committee and consider authorizing contracts to spend $5 million to create a digital peer support network for children and youth who have been bullied based on their race, ethnicity, language, or country of origin.

- Public Comment
- Vote

1:00 PM **Adjournment**

AGENDA ITEM 1

Action

November 18, 2021 Commission Meeting

Approve October 28, 2021 MHSOAC Teleconference Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the October 28, 2021 Commission teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None

Enclosure: October 28, 2021 Meeting Minutes

Handouts: None.

Proposed Motion: The Commission approves the October 28, 2021 meeting minutes.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM
Governor

Lynne Ashbeck
Chair
Mara Madrigal-Weiss
Vice Chair
Toby Ewing, Ph.D.
Executive Director

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Teleconference Meeting
October 28, 2021

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

819-5615-4753; Code KP$Rd7p

Members Participating:

Lynne Ashbeck, Chair
Mayra Alvarez
Ken Berrick
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Steve Carnevale
Shuonan Chen
Senator Dave Cortese
Itai Danovitch, M.D.
David Gordon
Gladys Mitchell
Khatera Tamplen
Tina Wooton

Members Absent:

John Boyd, Psy.D.
Assembly Member Wendy Carrillo
Mara Madrigal-Weiss, Vice Chair

Staff Present:

Toby Ewing, Ph.D., Executive Director
Anna Naify, Consulting Psychologist
Maureen Reilly, Acting General Counsel
Norma Pate, Deputy Director, Program, Legislation, and Administration
Brian Sala, Ph.D., Deputy Director, Research and Chief Information Officer
Tom Orrock, Chief of Stakeholder Engagement and Grants
Sharmil Shah, Psy.D., Chief of Program Operations

CALL TO ORDER

Chair Lynne Ashbeck called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:02 a.m. and welcomed everyone.

Amariani Martinez, Commission staff, reviewed the meeting protocols.

Chair Ashbeck gave the announcements as follows:

Announcements

- The next MHSOAC meeting is scheduled for Thursday, November 18th. The agenda will be posted on November 8th.
- The September 2021 Commission meeting recording is now available on the website. Most previous recordings are available upon request by emailing the general inbox at mhsoac.mhsoac.ca.gov.
- The Commission will be creating a new subcommittee named the Children's Mental Health Subcommittee. Commissioner Berrick has been appointed to serve as the Subcommittee Chair and Commission Chair Ashbeck will serve as the Subcommittee Vice Chair.
    - The purpose of the Subcommittee is to enhance the integrations of Commission strategies to support the needs of children and youth. The Subcommittee will also support the Governor's Children and Youth Behavioral Health Initiative, including ways to support the sustainability of the Governor's priorities as outlined in the initiative.
- Due to the number of action items that need Commission review and approval, and in consultation with Commissioners Boyd and Danovitch, the Chair and Vice Chair respectively of the Subcommittee on Innovation, the Help@Hand Update will be moved to the first quarter of the new year.
- On November 5th, Commissioner and Santa Barbara County Sheriff Bill Brown will join other subject matter experts on a panel highlighting opportunities for crisis services during the virtual Words to Deeds Conference. Moderated by Commission Research Supervisor Ashley Mills, this panel will include presentations and discussion on the new 988 number and local efforts to implement the Crisis Now Model and a law enforcement/mental health co-responder approach to people in crisis.

Staff Changes

Chair Ashbeck invited Dr. Brian Sala, Deputy Director of Research and CIO, to share recent staff changes. Deputy Director Sala announced that Dawnte Early, Ph.D., Chief of the Research and Evaluation Division, has been named President and CEO of United Way California's Capital Region. He wished Dr. Early all the best in her new position.

Deputy Director Sala stated two new staff have joined the Commission since the last Commission meeting through a UCSF contract and will be working on the Triage Summative Evaluation work. He introduced Martha Clemente, the new Triage

Evaluation Project Manager, and Manuel Andrade, the new Research Data Analyst for this work.

On behalf of the Commission, Chair Ashbeck welcomed Martha Clemente and Manuel Andrade to the Commission.

Chair Ashbeck stated Kayla Landry has accepted a position with the Department of Public Health's Prenatal Disease Screening Unit in Alameda County. She thanked her for her hard work and wished her all the best in her future endeavors.

Research and Evaluation Committee Update

Commissioner Danovitch, Chair of the Research and Evaluation Committee, provided a brief update of the work of the Committee since the last Commission meeting:

- The Commission's research was featured at the American Public Health Association meeting.
- Committee leadership met with staff to review the Commission's current research and evaluation priority areas and to discuss their alignment with the Commission's strategic goals to engage in strategic planning.

Client and Family Leadership Committee Update

Commissioner Tamplen, Chair of the Client and Family Leadership Committee (CFLC), provided a brief update of the work of the Committee since the last Commission meeting:

- The CFLC met on October 19th to continue its work on the Peer Specialist Certification Implementation Guide. The Committee received an update from the California Mental Health Services Authority (CalMHSA).
- Meeting participants advocated for an open process for providing input that includes all perspectives, especially from underserved racial and ethnic groups.
- The Committee will continue to collect helpful resources to be made available to counties that are implementing their peer support certification program. Resources received to date have been posted on the website.
- The next CFLC meeting is scheduled for December 9th.

Cultural and Linguistic Competency Committee Update

Commissioner Alvarez, Chair of the Cultural and Linguistic Competency Committee (CLCC), thanked Tom Orrock, Chief of Stakeholder Engagement and Grants, and Richard Zaldivar, CLCC Member, who facilitated the July CLCC meeting during her leave of absence. She provided a brief update of the work of the Committee since the last Commission meeting:

- The CLCC members discussed racial equity and how mental health programs can better meet the needs of diverse communities. The Committee heard a presentation from members of the California Reducing Disparities Project (CRDP) providing more detail on their programs and initiatives.

- The October CLCC meeting was rescheduled to November 10th.

Roll Call

Maureen Reilly, Acting General Counsel, called the roll and confirmed the presence of a quorum. Four members were recorded as Absent: Vice-Chair Madrigal-Weiss, Commissioner Boyd, Commissioner Carrillo and Commissioner Wooten.

GENERAL PUBLIC COMMENT

Craig Durfey, Founder, Parents for the Rights of Developmentally Disabled Children (PRDDC), cautioned against using the label of "mental illness." The speaker encouraged the Commission to support Assembly Bill (AB) 2417, which will bring activities that will help negative mental health consequences. The speaker submitted their full written comment to staff.

Stacie Hiramoto, Director, Racial and Equity Mental Health Disparities Coalition (REMHDCO), spoke about Senate Bill (SB) 1004, which was signed into law in 2018 and mandated that the Commission establish new prevention and early intervention (PEI) priorities. The Commission formed the PEI Subcommittee in response to SB 1004. The speaker provided input on behalf of REMHDCO and the CRDP leadership prior to the completion of the PEI Subcommittee report regarding the development of the new PEI priorities as follows:

- The REMHDCO and the CRDP leadership strongly recommend that transition-age youth (TAY) who are not in college are added to the list of priorities.
- The REMHDCO and the CRDP leadership strongly recommend that programs utilizing community-defined evidence-based practices (CDEPs) are added to the list of priorities in some way.

Poshi Walker, LGBTQ Program Director, Cal Voices, stated the assumption that the Commission falls under the entities listed in Government Code, Article 9.5, Discrimination. Over three years ago, the speaker informed the Commission and the staff that the speaker's pronouns were ze, zir, zirs, which are mentioned as part of the introduction prior to making public comment, included on all email communications, and included in zir Zoom name, yet ze has been consistently misgendered and spoken about by Commissioners and staff in a way that dismisses the speaker's gender identity.

Poshi Walker stated, when misgendered multiple times at the last meeting, ze offered culturally appropriate and best-action suggestions to the executive director via text messaging but has received no response to those suggestions, including the offer to provide training on this matter. Misgendering may not be intentional; however, not taking action when it happens over and over can be seen as discriminatory behavior and harassment, which goes against the Government Code.

Poshi Walker stated this issue is not just about zir but stated concern that trans people, which includes non-binary people, are some of the most vulnerable consumers. The speaker would not want any trans person hoping to interact with the Commission to be

dissuaded out of fear of being misgendered. Also, when a trans person witnesses a misgendering, that alone can be traumatic, even when not happening to them personally.

Poshi Walker stated misgendering will happen. What is most important is how it is handled when it does. The best way to handle misgendering someone who is present is to repeat what was just stated using the correct name, pronoun, or honorific. Keep apologies brief so it does not become about the person making the mistake. Saying things such as “I can do better,” “I’m trying really hard,” “Darn, I can’t believe I messed up again,” or “It’s hard because I used to know you before” makes it about the person who made the mistake and creates a climate where the injured person now feels compelled to comfort the person who made the mistake. These statements also imply that the trans person is putting an undue burden on others, thus, adding to the injury already inflicted by the original misgendering.

Poshi Walker stated the hope that the Commission will take action beyond apologies to alleviate misgender discrimination and assure that it does not continue.

Chair Ashbeck extended apologies as part of the Commission and staff to all that may have been misgendered. She thanked Poshi Walker for raising this issue and suggested including a brief training on this issue at the next meeting. It is a lesson everyone can benefit from.

Mary Ann Bernard, retired lawyer, family member, and advocate for the severely mentally ill, reminded Commissioners that the last clause of Section 5840(c) of the Mental Health Services Act (MHSA) has always provided that the Commission shall include relapse prevention and early intervention for individuals who already have existing severe mental illness in PEI. It is a mandatory category. Commission predecessors were forced by the Office of Administrative Law (OAL) to include relapse prevention and early intervention in existing regulations. SB 1004 does not and could not change that.

Mary Ann Bernard also reminded Commissioners that, if the Commission ignores this again, there is an easy route back to the OAL, which will probably go into rulemaking, which is burdensome and time-consuming. The speaker stated the hope that it will not be necessary to force the Commission to comply again.

Mary Ann Bernard stated, if the Commission wants to focus on the upstream end of PEI, which is what SB 1004 was about, which does not prevent mental illness or trauma but rather presents mental illness from becoming severe mental illness, the Commission can comply with this mandatory provision by declaring in their priorities that PEI can be used for two important programs that are already in the MHSA at Section 5813.5(f) – Laura’s Law and diversion and reentry programs for severely mentally ill individuals who are either headed into or out of local jails, which is where they end up in overwhelming numbers and is the last place that is healthy for them.

Mary Ann Bernard stated this Commission has the talent to do more than that with PEI and to be more creative about what to do. If the Commission will simply allocate funds to those two provisions, which are already part of the law, it will save lives, reduce crimes, eliminate human misery for severally mentally ill individuals and their loved ones

and the public, including all members of all protective groups because severe mental illness crosses all lines. That should be a priority in the upcoming PEI update.

Steve McNally, family member, stated families and consumers have been so marginalized. Not all families make it through these journeys intact and not all individuals make it through alive. The communication flow is horrendous. Local boards and commissions appointed by the state do not do their mandatory duties. Notices from the Department of Health Care Services (DHCS) do not include the local boards and commissions. The speaker asked the Commission to make it clear what MHSA funds can and cannot be used for. It is important to point to the policies that back up strong statements.

Hannah Bichkoff, Policy Director, Cal Voices, asked about meeting duration and agenda development. The speaker asked why Commission meetings have been shortened to four hours when they were previously an entire day. It is important to allow enough time for effective discussion of matters that are most important to stakeholders and communities.

Derek Duong, California Youth Empowerment Network (CAYEN), stated prioritizing mental health services for TAY on college campuses misses connecting with the significant number of TAY who are not enrolled in college. The speaker requested that the PEI Regulations not prioritize TAY on campuses and that the PEI Regulations include community-defined evidence-based practices.

Sonya Young Aadam, CEO, California Black Women's Health Project, echoed the comments of Derek Duong and Stacie Hiramoto that TAY who are not in college should also be included in PEI services and that the PEI Regulations should include community-defined evidence-based practices.

Nina Moreno, Ph.D., Director of Research and Strategic Partnerships, Safe Passages, and one of 35 local evaluators with the CRDP, agreed with Poshi Walker's comments. The speaker asked about the timeframe for the draft release of the PEI priorities. The speaker stated Safe Passages as well as other organizations within the CRDP Phase 2 support adding TAY youth and community-defined practices to the new list of priorities.

Fausto G. Novelo, Director of Operations and Clinical Counselor, Integral Community Solutions Institute (ICSI), a CRDP project, agreed with Stacie Hiramoto's comments. It is crucial to provide support for the 35 implementation pilot projects (IPPs) of the CRDP during the two-month gap in CRDP funding, since many IPPs have no other source of funding.

ACTION

1: <u>September 23, 2021, MHSOAC Meeting Minutes</u>

Chair Ashbeck stated the Commission will consider approval of the minutes from the September 23, 2021, teleconference meeting.

Public Comment

Poshi Walker requested that action items be recorded in the minutes. The speaker gave the example of the Colusa Innovation Project that had been approved by Chair Ashbeck and Executive Director Ewing that stated "both genders will be served, male and female." When the speaker brought this up at the August 26th meeting, Chair Ashbeck stated she was unaware and would look into it. This promise of action was not recorded in the August 26th minutes. The speaker asked how advocates and others can ensure that items are addressed in the future when an action item is not recorded in the minutes.

Poshi Walker referred to pages 6, 8, and 12 and stated the pronoun "they" was used for the speaker. Poshi Walker uses ze/zir, not they/them. As the scribe did choose to use the correct pronouns for cisgender speakers, it could be considered discriminatory that cisgender pronouns are honored while Poshi Walker's pronouns are not.

Poshi Walker requested that the speaker's pronouns be corrected in today's minutes and strongly urged that the Commission develop a protocol to assure that no one is mispronounced or misgendered in the minutes. This can include a protocol that everyone is addressed as they/them, that no pronouns are used, or that the scribe be made aware of the person's pronouns and uses them correctly.

Chair Ashbeck asked staff to correct the minutes on pages 6, 8, and 12, as noted by Poshi Walker. She asked for a motion to approve the minutes.

Commissioner Danovitch made a motion to approve the September 23, 2021, teleconference meeting minutes.

Commissioner Brown seconded.

Action: Commissioner Danovitch made a motion, seconded by Commissioner Brown, that:

- *The Commission approves the September 23, 2021, Teleconference Meeting Minutes as revised.*

Motion carried 10 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Berrick, Brown, Carnevale, Chen, Cortese, Danovitch, Gordon, Mitchell, Tamplen, and Chair Ashbeck.

The following Commissioner abstained: Commissioner Bunch.

The following Commissioner was recorded as No Response: Commissioner Alvarez. Four Commissioners were Absent, as recorded at Roll Call.

ACTION

2: <u>Mental Health Student Services Act</u>

Presenter:

- Tom Orrock

Chair Ashbeck stated the Commission will be presented with an outline for the allocation of additional funding to support the Mental Health Student Services Act (MHSSA) grants and request that the Commission delegate authority to the Executive Director to award grants to the highest scoring applicants.

Commissioners Berrick and Tamplen recused themselves from the discussion and decision-making with regard to this agenda item pursuant to Commission policy.

Chair Ashbeck asked staff to present this agenda item.

Tom Orrock, Chief of Stakeholder Engagement and Grants, provided an overview, with a slide presentation, of the background, original grant awards, community engagement with counties that did not originally apply, procurement plan, and timeline of the State Fiscal Recovery Funds (SFRF) Request for Applications (RFA) to award federal grants and enter into contracts with the remaining eligible counties. He stated, while this is a competitive process, all applicants that meet the requirements will receive funds. He noted that including both steps of issuing an RFA and entering into contracts in one motion will help expedite the process to provide much-needed services to students.

Mr. Orrock also clarified that there will be funding allocations for small/medium/large counties the same as in the prior release of state-funded MHSSA grants. As such, he said, there will be federal funds remaining from this release in the amount of approximately $22 Million. He also anticipated another release of state funds for MHSSA grants of approximately $15 Million, for a total of $37 Million.

Commissioner Questions

Chair Ashbeck asked if small counties will be given the option to use successful models rather than starting from scratch.

Mr. Orrock stated this is often done. The remaining 20 counties in particular were matched up, when possible, with like counties or counties that were proposing similar programs.

Public Comment

Poshi Walker commended the Commission’s sensitivity to challenges faced by small rural counties. While the RFAs for counties differ from the Request for Proposals (RFPs) for stakeholder advocacy contracts or community-based organizations, the speaker asked for that same sensitivity for future RFPs with community-based organizations that work with marginalized communities and face the same types of challenges that small counties face.

Tara Gamboa-Eastman, Legislative Advocate, Steinberg Institute, stated the Steinberg Institute is thrilled to see these programs expanded statewide and is grateful for the technical assistance being provided to small rural counties.

Steve McNally thanked staff for their willingness and openness to listen and sit down with counties to solve problems. This is analogous to what smaller organizations have to go through with the county procurement process. One answer to equity is responsive funding mechanisms that make is simpler and easier for smaller groups that are doing the work but are not on a big payroll to do that work. The speaker suggested that the

Commission foster the belief in responsive funding mechanisms, which will provide funding to the user.

Sonya Young Aadam agreed with Poshi Walker's comments. The speaker stated the hope that there will be equity considerations across the board for this funding for these school programs. The speaker stated this is an exciting opportunity for the state to support student mental health in particularly students of color and in historically marginalized communities who are disproportionately impacted. The speaker is excited that there is funding for COVID-19 stress disorder and intention investments in youth behavioral health.

Angela Vazquez, Mental Health Policy Director, Children's Partnership, stated this is an opportunity for the Commission and the state to support California's youngest learners ages 0-5. Most children in child care and preschool programs are not connected to a large county agency like a county office of education but rather are in small, community-based organizations. Learning and social-emotional development begins at birth. The speaker asked that the technical assistance is mindful of supporting counties in reaching out to small community-based organizations that are providing child care and preschool services to these young children.

Amelia, Sacramento State School of Social Work, applauded the word being done for student mental health and highlighted the need for behavioral health services post-pandemic. The speaker looks forward to how this will play out in schools and particularly the role social workers can play in carrying out these services.

Commissioner Discussion

Commissioner Gordon thanked the Commission and Executive Director Ewing for launching this effort, which now has an opportunity to be statewide. He stated the county superintendent's organization is standing alongside the Commission in terms of offering help to colleagues across the state to do what it takes to make this work.

Commissioner Gordon moved approval of the staff recommendation.

Commissioner Carnevale seconded.

Chair Ashbeck stated it is a big milestone for the state for every county in California to have the chance to do this for their children. She thanked Commissioner Gordon for his leadership in this effort as well.

Commissioner Gordon stated every county has their eye on the 0-5 space as the jumping-off point through First 5s and other advocates to make that happen in 0-5 as well.

Action: Commissioner Gordon made a motion, seconded by Commissioner Carnevale, that:

- *The Commission authorizes the Executive Director to issue the Request for Applications to award federal grants and enter into contracts with eligible counties.*

Motion carried 9 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Brown, Bunch, Carnevale, Chen, Cortese, Danovitch, Gordon, and Mitchell; and Chair Ashbeck.

Commissioners Berrick and Tamplen abstained and rejoined the meeting after the vote.

Five Commissioners were Absent, as recorded at Roll Call; and Commissioner Alvarez was also Absent for this vote.

BREAK

INFORMATION

3: <u>Panel on the Mental Health Wellness Act/Triage Grant Program</u>

Presenters:

- TBD, California Department of Aging
- Veronica Kelley, Director, San Bernardino County Behavioral Health and President, County Behavioral Health Directors Association
- Scott Zeller, Vice President for Acute Psychiatry at Vituity
- Jackie Wong, Chief Deputy Director of First 5 California

Chair Ashbeck stated the Commission will hear from presenters on opportunities for the next round of the Mental Health Wellness Act/Triage Grant Program. She noted that the representative from the Department of Aging had a scheduling conflict and will be unable to join the panel today but they will be invited to provide their perspective later. She asked Executive Director Ewing to introduce the members of the panel.

Executive Director Ewing stated the Commission’s budget includes an ongoing $20 million a year to support the SB 82 Mental Health Wellness Act. The Commission makes these grants available to county behavioral health departments to build out the continuum of care to reduce unnecessary hospitalizations and to reduce law enforcement involvement.

Executive Director Ewing stated the funding is used to hire staff for crisis services. The Commission has prioritized half of the funds for children and the other half for TAY and adults to fill gaps in the continuum of care and to incentivize partnerships between counties and schools.

Executive Director Ewing reviewed a slide on Commission key initiatives and opportunities that showed a graphic of programs funded by the Commission across the lifespan. He stated the goal of this agenda item is not to decide how to spend the funding but to facilitate a conversation with subject matter experts about the opportunity for this funding and how the Commission can be as impactful as possible with these limited resources.

Commissioner Questions

Chair Ashbeck noted that the graphic shows that mental health is not a series of funded projects that are not connected to each other. There is a lifecycle opportunity around mental health with lifecycle challenges and interventions.

Presentations

Executive Director Ewing asked Dr. Kelley to discuss the needs and opportunities that counties see for deploying this funding.

Veronica Kelley, DSW, Director, San Bernardino County Behavioral Health and President, County Behavioral Health Directors Association (CBHDA), provided the county perspective on the SB 82 Triage Program. She stated this funding has been essential for many counties to build out their crisis continuum and has unknowingly helped prepare counties for the upcoming shift in crisis response at the national and state levels.

Dr. Kelley provided an overview of San Bernardino County's Triage Engagement and Support Teams (TEST) program. She stated program staff are diverse individuals with lived experience who are trained in crisis response and how to activate individuals into service. The program is co-located in police departments, sheriff's offices, and emergency departments. She noted that there is not one solution; different levels of care are required.

Dr. Kelley discussed trends seen at the county level that impact crisis services across the state:

- It is important to remember that each geography and each community is different and that populations vary greatly county to county.
- The 988 national suicide prevention line. Some counties have robust crisis systems of care while others do not.
- Some counties have collaborative relationships with law enforcement while others do not. It is important to work together on this. This is key especially in the current climate with regards to equity and social injustice because in this case social issues are being used to create change.

Dr. Kelley discussed things to consider for these types of grants:

- Economy of scale and availability of workforce required.
- Crises happens to everyone.
- Communities are not aware of the public behavioral health system until they need it.
    - The behavioral health system needs to do a better job of telling the story and reminding individuals of what it does and who it serves and that it is the safety net. Even for the most regimented systems, relationships to communities vary greatly.

- Triaging a community is very effective and is an excellent intervention with many success stories, which shows the power of what triage grant funding can be used for.
- No matter how effective an intervention is, there will still be individuals who will be better treated at this moment in time in a hospital level of care.
    - Emergency departments are not the best place for psychiatric crises to be treated because emergency departments are not set up for the whole person.
    - This can be changed with legislation that requires a psychiatric consultant in emergency departments with funding to follow patients.
- Flexibility is key. County behavioral health is cost-reimbursed and cannot expand or change current programming without additional funding. It would be helpful for counties to be able to use these funds to enhance and expand their existing programs and services.
- There is a need for long-term funding for sustainability.
- Have a realistic timeline. There is not enough time to meet federal, state, and local requirements.
- Have multiple options.
- Include opportunities to address equity.
- Pass funding through counties to community-based organizations to contract for culturally appropriate options.
- Make funding available to train partners in the school system, law enforcement, and the court system on equity issues. Behavioral health has come a long way as far as equitable practices, but many partners have not.
- Amend the statute to allow for flexibility to cover the entirety of a program's operations, not just staffing.
- Include program-specific data collection and analysis rather than limiting the parameters and indicators of success.
- Avoid only covering certain specific interventions by the grant while other interventions are not.
- Intervening in a crisis and preventing the next one goes hand-in-hand. This is allowable and billable as part of the continuum of care.
- Include flexibility for these funds for individuals experiencing mental health issues but whose current crisis is being unhoused.
    - Funding for the unhoused does not often include supportive services.
- Prioritize grants that go to systems that partner internally with other groups and community-based organizations that can do this better and more effectively.

Scott Zeller, M.D., Vice President for Acute Psychiatry at Vituity, stated many community-based crisis programs have been created with the hopes of reducing emergency department use for psychiatric patients, but the number of behavioral health patients coming to hospital emergency departments has only increased during the past ten years. Patients are often too acute for community programs, which are mainly set up for patients with mild to moderate symptoms.

Dr. Zeller stated a focus on treatment is the missing link that can happen within an emergency room setting. Care should begin in the emergency department but emergency departments are not set up for behavioral health care. This does not mean that something better cannot be set up in the hospital.

Dr. Zeller provided an overview, with a slide presentation, introducing the Emergency Psychiatric Assessment Treatment Healing (EmPATH) Model, a wellness and recovery-oriented approach, as a way to transform emergency psychiatry and reduce unneeded hospital admissions. He stated grant program pairing hospitals and county mental health agencies to create EmPATH together would lead to new programs across the state.

Jackie Wong, Chief Deputy Director of First 5 California, provided the background of First 5 California. She noted the recent declaration of a national emergency in child and adolescent mental health by the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the National Children's Hospital Association. She shared stories of families on the front lines of this mental health crisis initiative and highlighted the struggle of many families who are trying to navigate a system that does not meet the needs of young children.

Ms. Wong stated Dr. Burke Harris's Roadmap for Resilience: the California Surgeon General's Report on Adverse Childhood Experiences (ACEs), Toxic Stress, and Health helps to create a framework to better understand the behavioral health care needs of young children. She stated the impact is more severe in communities of color.

Ms. Wong stated California children and families are under significant stress both from the COVID-19 pandemic and other underlying systemic issues of poverty, racism, and trauma. There is an urgent if not critical need to invest in programs for the 0-5 age group. She noted that, if left untreated, this will lead to poor chronic health outcomes, more severe mental and behavioral health issues, and other negative social outcomes such as incarceration, substance abuse, long-term unemployment, housing, and disabilities.

Ms. Wong stated this also disproportionately impacts the most marginalized communities who are more often communities of color living in poverty. She urged the Commission to consider targeting the SB 82 Triage Grants for 0-5 to help build the infrastructure for families. It is important to create systems that are trauma-informed and healing-centered.

Commissioner Discussion

Commissioner Bunch asked about next steps and how the Commission can uplift the EmPATH Model.

Dr. Zeller suggested helping counties to see the value in the EmPATH Model by educating them that the EmPATH Model can fill the missing part of the spectrum and encouraging counties to agree to provide the standard crisis stabilization reimbursement.

Commissioner Tamplen asked if the EmPATH Model allows individuals access to their family and friend support system.

Dr. Zeller stated families and other involved loved ones and care givers are extremely important for recovery, wellness, and long-term stabilization; however, the EmPATH unit is a treatment space that is an enclosed setting. It is a calming space meant for intensive care for a few hours. Family members do not enter this space because trials showed that it can become disruptive. Perhaps the family member did not understand what was going on or they would start some of the behaviors that led to the crisis in the first place, which would change the calming environment.

Dr. Zeller stated, as a way to work with families without disrupting that calming atmosphere, most EmPATH units have a family consultation room just outside of the milieu where staff can meet with family members and, if appropriate, the patient can come out of the milieu, meet with the family members, and have an expanded family therapy session. Oftentimes, patients do so well in those family meetings that the patient can go home with the family or disposition and follow-up appointments can be discussed at that time.

Commissioner Tamplen stated cell phones are taken from patients but cell phones contain apps to help individuals with their wellness. She asked if this area is addressed in the EmPATH Model.

Dr. Zeller stated this is an area many programs struggle with. He noted that the problem with cell phones is the photo and video recording capacity. Individuals have a right to privacy and the Health Insurance Portability and Accountability Act (HIPPAA) standards must be complied with. He stated the need to consider how individuals can still have their ability to communicate while limiting photo and video recording. Some EmPATH units address this by giving patients an opportunity to write down phone numbers from their cell phones during the intake process, providing patients access to cordless phones that can be checked out from the nursing station, and providing access to a desktop computer with Internet access for emailing or looking up information on wellness and recovery.

Commissioner Danovitch asked where the EmPATH Model fits into the landscape of urgent care and psychiatric emergency departments and how to leverage it to raise the level across the board. He suggested talking with Dr. Zeller offline.

Commissioner Danovitch stated the failure of private hospitals and counties to establish contracts to make models like this available is something that is deserving of the Commission’s attention. He stated there is a huge opportunity to unlock value for patients, health systems, and payers across the board, and EmPATH and other models are great model programs to do that. He suggested that the Commission can help bring private and public entities together for advancement.

Commissioner Brown stated all counties struggle with the same problems but have different approaches to them, depending on the scope, complexity, and resources in each county. He noted that there is no one-size-fits-all solution and many times partnerships with law enforcement are proving to be very effective. He stated appreciation for Dr. Kelley's presentation about how successful a partnership with law enforcement and behavioral health professionals can be, such as in Santa Barbera County's successful program.

Commissioner Brown stated he is intrigued with the EmPATH Model and particularly liked the acronym and the last word that focuses on healing. He stated Santa Barbara County has a similar program soon to be launched in partnership with the hospital that is a hospital-based Crisis Stabilization Unit (CSU). He stated he will share information on the EmPATH Model with the hospital. He suggested that there may be other similar programs that could be expanded into the EmPATH Model.

Dr. Kelley asked about the ability to bill commercial insurance with the EmPATH Model so there are other funding streams besides Medi-Cal, which requires a match. Regulations tie counties' hands.

Chair Ashbeck stated EmPATH Models are for adults. She asked if the model connects with pediatrics departments.

Dr. Zeller stated there are several EmPATH units across the country that see adolescents and the Minneapolis unit is building their fourth EmPATH unit that will be specifically for children and adolescents. They plan to change the approach to include individual calming rooms so children can be in there with their family members with the opportunity to move into the larger milieu space when they are comfortable.

Ms. Wong noted that adolescent care is different from 0-5 care. The EmPATH Model is only being used for older youth. She stated mental health crisis does happen in the 0-5 age range. This needs to be invested in because the treatment modality is completely different for adolescents. Caregivers and parents are a necessary part of the treatment intervention for the 0-5 age group. The pandemic has shown that the 0-5 population should have been a focus all along.

Commissioner Berrick emphasized Dr. Kelley's comments about integrated systems and added to Ms. Wong's comments about the fact that parents do not know how to access help for their children in a seamless way, particularly young children. He noted that what has not yet been discussed is the interaction between mobile crisis response and these alternatives to hospitals. He stated integrated systems should have an ability to provide mobile crisis responses first and to have a CSU or a wellness inpatient center 23-hour option available.

Commissioner Barrick stated what is most important is that community members and family members know who to call in a seamless way when someone is in crisis. He suggested linking efforts in mobile response with these alternatives in ways that the community is aware seamlessly of the availability for greater impacts. He suggested that the Commission prioritize scaling this in a way that is not the exception but is the rule about how to think about intervention.

Commissioner Gordon stated the need to invest in both of these priorities. He stated the 0-5 space has been underserved for so long. He noted that it doubles the value in the investment to not only invest in solving crises for young people at that point but to also invest in helping educate the family in how to avoid crises like that in the future to hopefully then avoid more of the adult issues being dealt with down the road. He encouraged investing in both.

Commissioner Mitchell stated concern about individuals who do not have a family member or friend available to speak for them during a crisis. She suggested having mentors or people on the ground to do prevention work to help with individuals before they get into a situation where they have to come into an EmPATH center. She also asked if these individuals are discharged into some type of community-based program.

Dr. Zeller stated EmPATH units are set up for patients who would otherwise be stuck in an emergency room. He stated there are great community-based programs but those are usually run through the counties. The EmPATH Model is specifically created for individuals who have tried other alternatives that did not work for them and they are now in the emergency room. He stated avoiding having to go to the emergency room in the first place is the goal, but if someone does end up in the emergency room, the goal then is to do such a great job that the patient understands the experience in a much more therapeutic alliance fashion and may now see caregivers as their allies so they reach out earlier to these community-based organizations in the future.

Commissioner Carnevale stated he was struck by the fact that all these programs are needed and sound important and have massive returns on investment. He asked why everyone is not working together as a system to identify the total need and the total return on that need and to educate the state to try to get all these needs filled. Picking one program over another is just a needle in the haystack. He stated he would like to see a larger effort to understand the problem, solution, and return on investment.

Public Comment

Steve Leoni stated these are some of the most exciting things they have heard in a long time, particularly the EmPATH Model, which is in line with the intent of the MHSA. The speaker agreed with Commissioner Carnevale about collaborating with others. The speaker stated the hope that, if any legislation or other leverage is used, it will not be only about putting a bed in emergency units but that it preserves the values of the MHSA.

Poshi Walker spoke about the experience of LGBTQ individuals in the emergency room. LGBTQ individuals end up in the emergency room oftentimes because they avoid care, do not have insurance, or have had traumatic experiences with medical and mental health personnel in the past. Emergency department personnel often are not equipped and do not deal well with LGBTQ individuals, especially transgender individuals.

Poshi Walker stated concern that this does not include recognition of that. Even though 4.9 hours in the emergency room is better than 16 hours, it is still a long time. The speaker asked why patients cannot go directly to EmPATH if that meets their needs. The speaker also stated concern about the one-size-fits-all program. There is a big difference between different types of crises and the need to be treated differently.

Ruqayya Ahmad, California Pan-Ethnic Health Network (CPEHN), emphasized that without adequate behavioral health prevention, early intervention, and community-based care, Black, indigenous, and people of color (BIPOC) often live without acknowledge of or even treatment of their mental health needs. When they do require urgent care due to some crisis situation, these individuals are often harmed by law enforcement that responds to these situations.

Ruqayya Ahmad stated, because of this, CPEHN believes that an entirely alternative system of behavioral health urgent response needs to be created. The speaker stated CPEHN urges the Commission to stipulate that the third round of triage funding will not support programs with law enforcement involvement. The third round of funding should invest in other community alternatives in order to move forward.

Ruqayya Ahmad emphasized that, from the first point of contact, individuals should be able to receive services in their primary language. When thinking about the workforce for this response system, there should be a requirement for the workforce to represent the racial and linguistic diversity of the communities that they serve.

Ruqayya Ahmad stated CPEHN believes that evaluation and accountability measures that center around racial equity should be designed and that counties that receive funds should be required to collect robust demographic patient-centered measures. The speaker stated those should regularly be provided to the public to consistently work to improve the programs.

Kelly Morehouse-Smith, LMFT, Family Wellbeing Director, Child Care Resource Center (CCRC), stated treatment at an early age can often prevent mental health and behavioral issues from getting worse and resulting in school suspension or expulsion or requiring more intensive, expensive, and crisis-level mental health services in later years. Early intervention services improve long-term outcomes for children, their families, and ultimately, communities.

Kelly Morehouse-Smith stated it is important that the Commission consider opportunities to fund programs like home visiting and early childhood mental health consultation for early childhood education providers and families. These evidence-based programs and those like them are foundational for any comprehensive approach to this population. These programs also fit the prevention and early intervention component of the MHSA. The CCRC urges the Commission to consider how MHSA grant funds can be used to expand options for mental health services in the 0-5 population.

Nicole Wortleman (phonetic), The Children’s Partnership, stated The Children’s Partnership applauds the Commission for establishing a Children’s Mental Health Subcommittee. The speaker stated, given that 50 percent of mental health conditions appear before the age of 14 and the significant impact of adverse childhood experiences on the mental and emotional trajectory of children, this subcommittee will be essential for uplifting and strategizing around ensuring that children, especially those from historically marginalized communities, receive the necessary prevention, early intervention, and ongoing supports they need to thrive.

Nicole Wortleman (phonetic) stated The Children's Partnership echoes Ms. Wong's comments regarding the opportunity to be more explicit across state investments in mental health and how they impact very young children. The speaker stated the rapid brain development and the impact of trauma and toxic stress on the social-emotional development of young children absolutely sets the stage for future mental health outcomes as children grow into teens and adults. The Children's Partnership looks forward to working with the Commission to ensure that very young children ages zero to five are an explicit priority for the state and for the Commission.

Stacie Hiramoto stated the need for African American representatives and others to talk about their different experiences. The speaker stated the mental health community always divides things up by age but much can be learned by dividing the population in different ways.

Andrea Crook, Director of Advocacy, ACCESS California, a program of Cal Voices, stated having the EmPATH program can save years of the recovery journey because having that immediate connection with a peer and understanding that recovery is possible is not something that one should have to wait years to discover. The speaker asked if family members and supporters are also provided support services and resources while patients are receiving services in the EmPATH program, and if there are navigators and peer support specialists following patients once they are released.

Sarah Crow, Managing Director, First 5 Center for Children's Policy at the First 5 Association, echoed previous speakers and applauded the Commission for establishing a Children's Mental Health Subcommittee. The speaker stated the needs of infants and toddlers and their families are often overlooked in broader conversations about mental health.

Sarah Crow stated, during the first three years of life, the child's brain develops more rapidly than at any other point in their life. A baby's earliest relationships and experiences shape the architecture of the brain creating a foundation on how future development and learning unfolds. Young children under five can and do suffer from mental health conditions. In fact, they experience mental health issues at approximately the same rate as older children. Professionals serving in infant and childhood mental health require a specific set of approaches and skillsets.

Sarah Crow underscored the comments made by Ms. Wong about the importance of infant and early childhood mental health and the mental health crisis that families with young children are experiencing. The speaker stated this Commission has the ability to offer its powerful voice and leadership to ensure that communities across the state prioritize early childhood prevention, mental health promotion, and early intervention programs that are upstream and equitably serve California's families.

Tiffany Carter, Statewide Advocacy Liaison, ACCESS California, a program of Cal Voices, stated options for individuals coming into the emergency room is imperative. The speaker echoed Stacie Hiramoto's comments about how important representation is. BIPOC population engagement in this particular setting is strongly tied to having diverse service providers alongside peers. The speaker looks forward to the

enhancement of the advertisement of the EmPATH Model as it expands so the general public knows about it.

Tiffany Carter addressed the cell phone policy issue. The speaker noted that cell phones are not taken away from individuals in emergency rooms. Further discussion is needed about how to continue to provide individuals with this link of communication to loved ones during this critical state, such as text messaging or face time while still protecting the rights and privacy of others.

Chair Ashbeck wrapped up this agenda item by stating the point of this presentation was to help inform the Commission as it thinks about triage going forward. She noted that there will be other opportunities for discussion on this topic in the future and stated the Commission looks forward to hearing the Department of Aging's perspective at a later time.

Executive Director Ewing referred to Dr. Kelley's comment about the amount of time it takes to participate in a grant opportunity and stated the Commission has funding in its budget that is required to be encumbered prior to the end of June, which is the end of the fiscal year. Looking backwards from that date for the amount of time available to build into the process to ensure that these dollars can be deployed effectively, the goal is to bring a proposal forward as early as November. The more time the Commission can give local partners to work through the application process, the better.

Executive Director Ewing stated staff will work with the chair to put together a proposal for the Commission's consideration at the November meeting with the idea of releasing these funds in a way that is supportive of the priorities that were discussed today. There will be an opportunity at the November meeting to have further dialogue. He stated appreciation for the speakers' willingness to lay out opportunities and challenges to help provide context for the limitations and strengths of the SB 82 Triage Grant funding.

Executive Director Ewing agreed with Dr. Kelley that this may be an opportunity to work with the Legislature to modify SB 82 to provide additional flexibility in the near future, but noted that will not be possible prior to the release of Round 3 funding.

ADJOURNMENT

Chair Ashbeck stated the November meeting is the last Commission meeting in the calendar year, although Committees will continue to meet through December. There being no further business, the meeting was adjourned at 12:45 p.m.

AGENDA ITEM 2

Action

November 18, 2021 Commission Meeting

Election of the Chair and Vice-Chair for 2022

Summary: Elections for the Mental Health Services Oversight and Accountability Commission Chair and Vice-Chair for 2022 will be conducted at the November 18, 2021 Commission Meeting. The MHSOAC Rules of Procedure state that the Chair and the Vice-Chair shall be elected at a meeting held preferably in September but no later than during the last quarter of the calendar year by a majority of the voting members of the Commission. The term is for one year and starts January 2022.

This agenda item will be facilitated by Chief Counsel, Maureen Reilly.

Enclosures (1): Commissioner Biographies

Handout: None

Mental Health Services
Oversight & Accountability Commission

Commissioner Biographies
November 2021

Mayra Alvarez, Los Angeles

Joined the Commission: December 2017

Mayra Alvarez is the President of the Children's Partnership, a nonprofit children's advocacy organization.

She also serves as a First 5 California Commissioner, appointed by Governor Newsom. Previously, she served in the U.S. Department of Health and Human Services (HHS), most recently as Director of the State Exchange Group for the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services.

She also served as the Associate Director for the HHS Office of Minority Health and was Director of Public Health Policy in the Office of Health Reform at HHS. Alvarez received her graduate degree from the University of North Carolina at Chapel Hill and her undergraduate degree from University of California Berkeley. Commissioner Alvarez fills the seat of the Attorney General designee.

Lynne Ashbeck, Clovis

Current MHSOAC Chair

Joined the Commission: February 2016

Lynne Ayers Ashbeck, MS, MA, RD is the senior vice president of community engagement and population wellness for Valley Children's Healthcare.

She has also served as vice president at Community Medical Centers; regional vice president at the Hospital Council of Northern and Central California; and the director of Continuing and Global Education at California State University, Fresno.

She is an elected Councilmember in the City of Clovis, first elected in 2001, and has served two terms as Mayor. She is active in several community organizations, including the California Partnership for the San Joaquin Valley Board of Directors, Vice Chair of the Fresno County Transportation Authority, and a Board member of the Community Justice Center.

She received her Master of Arts degree from Fresno Pacific University, a Master of Science degree from California State University, Fresno and is a Registered Dietitian. Chair Ashbeck fills the seat of a representative of a health care service plan or insurer.

Ken Berrick, Oakland

Joined the Commission: December 2018

Ken Berrick is the founder and Chief Executive Officer of Seneca Family of Agencies. He serves on the California Child Welfare Council and co-chairs the Behavioral Health Committee, is a two-time former President of the California Alliance of Child and Family Services, a fellow of the Pahara Institute, and a member of the Alliance for Strong Families and Communities. Ken serves on the board of Support, Opportunities, and Rapport (SOAR) for Youth, has served as Trustee for Area 3 and Past-President of the Alameda County Board of Education since 2008, and is a Past-President of the California County Boards of Education. Commissioner Berrick fills the seat of a mental health professional.

John Boyd, Psy.D, Folsom

Joined the Commission: June 2013

John Boyd is Sutter Health's Chief Executive Officer of Mental Health Services. He has an extensive background in healthcare administration and mental health. Prior to joining Sutter in 2008, he served as Assistant Administrator for Kaiser Permanente Sacramento Medical Center and has worked as both an inpatient and outpatient therapist in several organizations.

He is a Board Member of National Mental Health America; he has also served in other appointed capacities, including City of Sacramento Planning Commissioner. Boyd is a Fellow with the American College of Healthcare Executives. He earned his doctorate in psychology at California School of Professional Psychology and his MHA from USC. Commissioner Boyd represents an employer with more than 500 employees.

Bill Brown, Lompoc

Joined the Commission: December 2010

Bill Brown was first elected as sheriff and coroner for Santa Barbara County in 2006, and reelected in 2010, 2014 and 2018. He had previously served as chief of police for the city of Lompoc from 1995-2007, and chief of police for the city of Moscow, Idaho from 1992-1995. He was a police officer, supervisor, and manager for the city of Inglewood Police Department from 1980-1992, and a police officer for the city of Pacifica from 1977-1980.

Prior to his law enforcement career, Sheriff Brown served as a paramedic and emergency medical technician in the Los Angeles area from 1974-1977. Sheriff Brown holds a master's degree in public administration from the University of Southern California and is a graduate of the FBI National Academy, the Delinquency Control Institute, the Northwest Command College, and the FBI National Executive Institute. Commissioner Brown fills the seat of a county sheriff.

Keyondria Bunch, Ph.D., Los Angeles

Joined the Commission: August 2017

Keyondria Bunch, Ph.D., is Supervising Psychologist for Los Angeles County Department of Mental Health. Dr. Bunch has been with Los Angeles County since 2008 and has worked in several positions including clinical psychologist and supervisor for the Emergency Outreach Bureau, clinical psychologist for the Specialized Foster Care Program, clinical psychologist for juvenile justice mental health quality assurance, and a clinical psychologist for Valley Coordinated Children's Services.

She has been an adjunct lecturer at Antioch University as well as worked within the mental health court system around issues of competency. Dr. Bunch is currently a supervising psychologist at West Valley Mental Health outpatient program. Commissioner Bunch fills the seat of a labor representative.

Assemblymember Wendy Carrillo, Los Angeles

Joined the Commission: February 2018

Wendy Carrillo was elected to represent California's 51st Assembly District in December 2017, which encompasses East Los Angeles, Northeast Los Angeles, and the neighborhoods of El Sereno, Echo Park, Lincoln Heights, Chinatown, and parts of Silver Lake.

She is a member of the Health, Appropriations, Utilities & Energy, Labor Privacy and Consumer Protections, and Rules Committees. Assemblymember Carrillo has advocated for educational opportunities, access to quality healthcare, living wage jobs, and social justice. She was host and executive producer of the community-based radio program "Knowledge is Power" in Los Angeles.

Her previous work with Service Employees International Union (SEIU) Local 2015 included better working conditions for caregivers. She arrived in the United States as an undocumented immigrant from El Salvador and became a U.S. citizen in her early 20s. Assemblymember Carrillo represents the member of the Assembly selected by the Speaker of the Assembly.

Steve Carnevale, San Francisco

Joined the Commission: April 2021

Steve Carnevale is the executive chairman of Sawgrass, a developer of digital industrial inkjet technologies and cloud-based mass customization software. He runs a family-owned wine business in the Napa Valley called Blue Oak and is the founder and chair of the advisory board for the UCSF Dyslexia Center which is translating cutting edge neuroscience to enable precision learning. In addition to other education non-profit board service, Carnevale is a founder and co-chairs Breaking-Barriers-by-8, where he works with other non-profits, schools, corporations, and foundations toward achieving 100 percent literacy for all by age 8. He is also an advisor to ESO Ventures, a social venture fund in Oakland for community workforce development of unrepresented populations and is the former President and

Emeritus Chair of The Olympic Club Foundation, whose mission is to support disadvantaged youth sports programs that develop future community leaders. Commissioner Carnevale represents an employer with fewer than 500 employees.

Shuo (Shuonan) Chen, Berkeley

Joined the Commission: April 2021

Shuo (Shuonan) Chen is General Partner at IOVC, an early-stage venture capital fund based in Silicon Valley focused on enterprise and SaaS, where she has invested in dozens of startups now unicorns or acquired by Fortune 50 companies. She is a Lecturer at the University of California, Berkeley, and Faculty at Singularity University, where she teaches entrepreneurship and emerging technologies. Chen is a co-author to one of the leading books on financial regulations published by Cambridge University Press. In addition to her investing and teaching roles, Chen is the CEO of Shinect, a Silicon Valley-based non-profit community of 5,000+ engineers passionate about entrepreneurship. She is also a Board Member of Decode, the largest tech and entrepreneurship community co-hosted with UC Berkeley and Stanford student organizations, alumni networks, and entrepreneurship centers, as well as an Advisory Board Member of Yale School of Medicine's Center for Digital Health and Innovation. Commissioner Chen fills the seat of a family member.

Senator Dave Cortese, Santa Clara

Joined the Commission: September 2021

California Senator Dave Cortese represents District 15 in the California State Senate which encompasses much of Santa Clara County in the heart of Silicon Valley. Along with his accomplished career as an attorney and business owner, the Senator previously served on the Santa Clara County Board of Supervisors, the San Jose City Council, and the East Side Union High School District Board. Senator Cortese was a major architect of School Linked Services, a program that connects students and families to behavioral health services and counseling in Santa Clara County. Commissioner Cortese fills the seat of a member of the Senate selected by the President pro Tempore of the Senate.

Itai Danovitch, M.D., Los Angeles

Joined the Commission: February 2016

Itai Danovitch, M.D., MBA is Chairman of the Department of Psychiatry and Behavioral Neurosciences at Cedars-Sinai Medical Center in Los Angeles since 2012, as well as Director of Addiction Psychiatry at Cedars-Sinai since 2008. His clinical practice and research focus on substance use disorders, as well as the integration of medical and mental health services. Dr. Danovitch is a Distinguished Fellow of the American Society of Addiction Medicine, a Fellow of the American Psychiatric Association and past president of the California Society of Addiction Medicine. Dr. Danovitch earned his medical doctorate from the University of California, Los Angeles School of Medicine and a Master of Business Administration degree from the University of California, Los Angeles Anderson School of Management. In his role as

Commissioner, Dr. Danovitch fills the seat of a physician specializing in alcohol and drug treatment.

David Gordon, Sacramento

Joined the Commission: January 2013

David W. Gordon is the Superintendent of the Sacramento (CA) County Office of Education. He holds a B.A. from Brandeis University and an Ed.M. and Certificate of Advanced Study in Educational Administration from Harvard University.
David has dedicated his career to education with a focus on Special Education. He has served on the President's Commission on Excellence in Special Education, the Governor's Advisory Committee on Education Excellence, and a visiting scholar at Stanford University.
Commissioner Gordon fills the seat of a superintendent of a school district.

Mara Madrigal-Weiss, San Diego

Current MHSOAC Vice Chair

Joined the Commission: September 2017

Mara Madrigal-Weiss is the Director of Student Wellness & Positive School Climate and Foster and Homeless Youth Education Programs with the San Diego County Office of Education.

Her experience includes working with school communities as a Family Case Manager, Protective Services Worker and Family Resource Center Director.

Mara received her M.A. in Human Behavior from National University; a M.Ed in School Counseling and a M.Ed in Educational Leadership from Point Loma Nazarene University. Mara has been dedicated to promoting student mental health and wellness for over 19 years. She is a past president of the International Bullying Prevention Association (IBPA) the only international association dedicated to eradicating bullying worldwide.

Mara is a member of the California Department of Education's Student Mental Health Policy Workgroup. At present, Commissioner Madrigal-Weiss fills the seat of the State Superintendent of Public Instruction designee.

Gladys Mitchell, Sacramento

Joined the Commission: January 2016

Gladys Mitchell served as a staff services manager at the California Department of Health Care Services from 2013-2014 and at the California Department of Alcohol and Drug Programs from 2010-2013 and from 2007-2009.

She was a health program specialist at California Correctional Health Care Services from 2009-2010 and a staff mental health specialist at the California Department of Mental Health from 2006-2007. She was interim executive officer at the California Board of Occupational

Therapy in 2005 and an enforcement coordinator at the California Board of Registered Nursing from 1996-1998 and at the Board of Behavioral Science Examiners from 1989-1993.

She is a member of the St. Hope Public School Board of Directors. Mitchell earned a Master of Social Work degree from California State University, Sacramento. Commissioner Mitchell fills the seat of a family member of a child who has or has had a severe mental illness.

Khatera Tamplen, Pleasant Hill

Joined the Commission: June 2013

Khatera Aslami Tamplen has been the consumer empowerment manager at Alameda County Behavioral Health Care Services since 2012.

She was executive director at Peers Envisioning and Engaging in Recovery Services from 2007-2012 and served in multiple positions at the Telecare Corporation Villa Fairmont Mental Health Rehabilitation Center from 2002-2007, including director of rehabilitation.

Tamplen is a member of the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services National Advisory Council and a founding member of the California Association of Mental Health Peer Run Organizations. Commissioner Tamplen represents clients and consumers

Tina Wooton, Santa Barbara

Joined the Commission: December 2010

Tina Wooton has worked in the mental health system for 23 years, advocating for the employment of consumers and family members at the local, state and federal levels. Since 2009 she has served as the Consumer Empowerment Manager for the Santa Barbara County Department of Alcohol, Drug, and Mental Health Services.

From 2005 through 2009 she worked as the Consumer and Family member liaison for the California State Department of Mental Health and was staff to the state Mental Health Services Act Implementation Team. Between 1997 and 2005 she served as Consumer Liaison for the Mental Health Association / County Mental Health of Sacramento and as service coordinator for Human Resources Consultants from 1994 through 1997.

Wooton is Vice President of AMP (Arts Mentorship Program) for Santa Barbara Dance Arts and a Santa Barbara Elks member. Commissioner Wooton represents clients and consumers.

AGENDA ITEM 3

Action

November 18, 2021 Commission Meeting

Shasta County Innovation Plan

Summary: The Commission will consider approval of the Shasta County request to expend up to $1,750,000 in MHSA Innovation funds over five years for the following new innovation project:

1. **Hope Park**

Shasta County is requesting up to $1,750,000 of Innovation spending authority to test a pilot program that will bring together youth and older adults in an effort to address challenges in both of these target populations.

Brought about by Shasta County Stakeholders who placed emphasis on wanting to develop one project inclusive of both young adults and older adults, this program will utilize two teen centers within the County that will allow for beneficial and meaningful interactions with the goal of reducing high Adverse Childhood Experiences (ACEs) for the young adults and reducing social isolation for the older adults.

Shasta County receives guidance from several committees and workgroups that help guide the planning and utilization of Mental Health Services Act funding. The idea for this project was developed by the MHSA Stakeholder Workgroup and was then assessed, and unanimously supported and approved by the County's Stand Against Stigma Committee, Suicide Prevention Workgroup, and the Mental Health, Alcohol, and Drug Advisory Board.

During the community planning process, two priorities were raised: 1) isolation and depression for older adults, and 2) the high rate of ACEs scores for teens. There were four different proposals discussed on April 9, 2019 at a stakeholder workgroup meeting, one of them being a project inclusive of older adults and young adults.

The proposed plan was posted for public comment beginning December 7, 2020 through January 6, 2021 followed by the Mental Health Board public hearing on January 6, 2021. The County's Board of Supervisors approved this project on March 2, 2021.

The County will be utilizing two teen centers, including a new center located in Redding and an existing teen center in Anderson (south of Redding). Historically, when older adults and youth are brought together, it is usually in places such as senior centers or adult care homes/nursing homes. For this project, older adult volunteers will gather where teens meet.

In an effort to reduce social isolation among older adults and mitigate risky behaviors among teens and preventing escalation of ACEs scoring, the County hopes to bring these two populations together in the teen centers to participate in a variety of meaningful interactions and activities including but not limited to: high-adventure activities, daily activities held at the teen centers, karate classes, yoga classes, cooking and basic life skills.

For this project, teens will be recruited via high schools, youth groups, community programs and referrals received through partnering agencies. Older adult volunteers will be recruited from several organizations within the County including but not limited to the Frontier Senior Center, Veterans of Foreign Wars, Adult protective Services, and the Older Adult Policy Council.

Shasta County and Pathways to Hope for Children will be contracting and working with Kidder Creek Adventure Camps to help facilitate the high-adventure activities: whitewater rafting, zip lines, ropes courses and more. These shared adventure activities will begin to create bonds and mentorship that the County hopes will carry into the daily interactions and activities held within the two teen centers among older adults and teens.

Pathways to Hope for Children will be working in partnership with the Tulsa's Hope Research Center located at the University of Oklahoma who will be tasked with completing the evaluation which is being provided as an in-kind donation.

Presenter for Shasta County's Innovation Project:

- Donnell Ewert, MHP, Director, Shasta County Health and Human Services Agency

Enclosures (3): (1) Biography for Shasta County's Innovation Presenter; (2) Staff Analysis: Hope Park; (3) Stakeholder feedback

Handout (1): PowerPoint will be presented at the meeting

Additional Materials (1): A link to the County's Innovation Plan is available on the Commission website at the following URL:

https://mhsoac.ca.gov/wp-content/uploads/Shasta_INN_Hope-Park.pdf

Proposed Motion: The Commission approves Shasta County's Innovation Project, as follows:

Name:	Hope Park
Amount:	Up to $1,750,000 in MHSA Innovation funds
Project Length:	5 Years

Shasta County Health & Human Services Agency | Office of the Director

Donnell Ewert Biography

Donnell Ewert, MPH, is Director of Shasta County Health and Human Services Agency (HHSA), a position he has held since November 2012. This Agency includes the functional areas of Alcohol and Drug Services, Mental Health Services, Public Health Services, and Social Services, organized into five branches. Prior to this assignment, Donnell was the Director of the Public Health Branch of the HHSA from 2006 to 2012, also serving for limited time periods as the interim director of the Regional Services Branch and the Adult Services Branch. Donnell started his work in Shasta County as an epidemiologist back in 1999 and held a variety of supervisory and management positions prior to becoming the Public Health Director in 2006. Donnell was employed as a communicable disease epidemiologist at the Los Angeles County Department of Health Services (1988-1993) and the Indiana State Department of Health (1993-1995) before working abroad in Kazakhstan (1995-1998) for a non-profit organization called Interlink Resources.

Donnell has participated in a variety of statewide organizations during his tenure in Shasta County, including the County Health Executive Association of California (CHEAC), the County Behavioral Health Directors Association (CBHDA), the County Welfare Directors Association (CWDA), the California Mental Health Services Authority (CalMHSA), the County Alcohol and Drug Administrators Association of California (CADPAAC), California Department of Public Health Office of Health Equity Advisory Board and the Child Nutrition Advisory Council of the California Board of Education. Additionally, he serves on the governing commission of Partnership Healthplan of California, the Medi-Cal managed care plan for 14 northern California counties, including Shasta, and the Community Corrections Partnership Executive Committee.

Donnell is the proud father of two adult daughters and one adult stepdaughter.

STAFF ANALYSIS – Shasta County

Innovation (INN) Project Name:	**Hope Park**
Total INN Funding Requested:	**$1,750,000**
Duration of INN Project:	**Five Years**
MHSOAC consideration of INN Project:	**November 18, 2021**

Review History:

Approved by the County Board of Supervisors:	March 2, 2021
Mental Health Board Hearing:	January 6, 2021
Public Comment Period:	December 7, 2020 – January 6, 2021
County submitted INN Project:	September 3, 2021
Date Project Shared with Stakeholders:	March 8, 2021 and October 22, 2021

Project Introduction:

Shasta County is requesting up to $1,750,000 of Innovation spending authority to test a pilot program that will bring together youth and older adults in an effort to address challenges in both of these target populations.

Brought about by Shasta County Stakeholders who placed emphasis on wanting to develop one project inclusive of both young adults and older adults, this program will utilize two teen centers within the County that will allow for beneficial and meaningful interactions and experiences between older adults and young adults with the goal of reducing or mitigating high Adverse Childhood Experiences (ACEs) for young adults and reducing social isolation experienced by older adults.

What is the Problem?

The County's stakeholder process revealed a need to address two priorities within the County: high Adverse Childhood Experience (ACEs) scores for teens and isolation among older adults, which has been exacerbated by the Pandemic. Statistics show that loneliness and social isolation increases the risk of dementia by 50% and mental health disorders increase by as

much as 26% (Parkman, K). The County indicates social isolation for older adults in the County is difficult to recognize and has become a higher concern due to the Pandemic and some may go days or weeks without any meaningful interaction with others.

Specific to ACEs scores, a 2012 study conducted in Shasta County revealed 29% of the 281 County participants disclosed an ACEs score of five or higher. In contrast, ACEs scores of five or higher occur in 9% of the population in other parts of the United States making ACEs scores much higher for residents in Shasta County compared with other parts of the Country. Individuals with higher ACEs scores are more at risk for depression, cancer, and diabetes a well as engaging in behaviors like smoking and heavy drinking. ACEs are described as potentially traumatic events occurring in childhood that may include violence, abuse, and growing up in an environment where there are mental health or substance abuse problems. These events can lead to health problems, mental illness, and a change in the development of the brain and how a body reacts to stress (CDC website).

The County has programs in place for teens; however, the County has acknowledged there is a lack of activities and resources for teens that would be considered high-risk. The County hopes that meaningful interactions between these two populations will be mutually beneficial resulting in the reducing the feeling of isolation in older adults and mitigating the risk of higher ACEs scores in youth.

How this Innovation project addresses this problem:

The positive effects from meaningful interaction have already made impressions among County residents. The County has referenced Shasta County resident and now an older adult, Laural Park who volunteered at Camp HOPE – a camp created specifically for children who have witnessed family violence. Inspired by a San Diego Program, Executive Director Michael Burke created Camp HOPE in 2012 which has grown nationally and is part of the Alliance for HOPE International. To this day, some of the older adult volunteer camp counselors at Camp HOPE attended Camp HOPE as youth, including Laural Park who remains active with Camp HOPE. As an adult, Laural has written a book (*Hope Rising: How the Science of Hope can Change Your Life*) sharing her story of childhood sexual assault which has prompted continued motivation and desire to help other teens overcome traumatic experiences toward a path of resiliency and wellness.

Although Camp HOPE was developed specifically for youth who have witnessed family violence, this project – HOPE PARK – will bring together at-risk teens and older adults together to create and share meaningful moments with the hopes of reducing social isolation for older adults and mitigating ACEs scores for teens.

The County will be utilizing two teen centers, a new center located in Redding and an existing teen center in Anderson, located just south of Redding. Historically, when older adults and youth are brought together, it is usually in places such as senior centers or adult care homes/nursing homes. For this project, older adult volunteers will gather where teens meet.

In an effort to reduce social isolation among older adults and mitigate risky behaviors among teens and preventing escalation of ACEs scoring, the County hopes to bring these two populations together in the teen centers to participate in a variety of meaningful interactions and activities including but not limited to: high-adventure activities, daily activities held at the teen centers, karate classes, yoga classes, cooking and basic life skills.

For this project, teens will be recruited via high schools, youth groups, community programs and referrals received through partnering agencies. Once selected to participate, the youth and their parents and/or guardians will become part of the Hope Park Project for the entire school year.

Older adult volunteers will be recruited from several organizations within the County including but not limited to the Frontier Senior Center, Veterans of Foreign Wars, Adult protective Services, and the Older Adult Policy Council (*see pg. 6 of plan for all listed organizations*).

All older adult volunteers will undergo a 20-hour training academy that may include, at minimum:

- Mental Health First Aid for Youth
- Suicide awareness
- Motivational Interviewing
- Healthy Relationships & Teen Dating Violence
- Sexual Assault Prevention & Intervention
- Domestic Violence Awareness
- Mandated Child Abuse Reporter Training
- Hope Theory
- Mentoring

Additionally, all older adult volunteers will undergo a background clearance, fingerprint clearance, and cleared through the National Sex Offender Registry before being onboarded and prior to any interactions with teens. Once cleared, older adult volunteers will staff the two teen centers from 3p-7p for a minimum of 4 hours per week. These volunteer hours are intentional as this is the time where teens can engage in risky behaviors, typically after school or while parents and/or guardians are still tending to the workday. The County will make efforts to pair older adults with teens having similar lived experience, . this will allow for greater bonding and understanding.

The County has received feedback from older adults in the development of this project that time would rather be deemed as volunteered as opposed to compensated as it may interfere with their retirement or other fixed income. Therefore, compensation will come in the form of stipends and all activities will be paid for by this project.

Shasta County and Pathways to Hope for Children will be contracting and working with Kidder Creek Adventure Camps to help facilitate the high-adventure activities: whitewater rafting, zip lines, ropes courses and more. These shared adventure activities will begin to create bonds and mentorship that the County hopes will carry into the daily interactions and activities held within the two teen centers among older adults and teens. Pathways to Hope for Children will be tasked with carrying necessarily insurances that will be needed for all participants engaging in activities for this project.

Both teen centers will be open to all youth and older adult volunteers and affirming to all who visit (regardless of gender identity, race, ethnicity, sexual orientation or religious belief) and hopes to serve the Native American population due to their connectedness with the Redding Rancheria.

Community Planning Process (*see pgs 12-15 of project plan*)

Local Level

During the community planning process, two priorities were raised: isolation and depression for older adults and the high rate of ACEs scores for teens. There were four different proposals discussed on April 9, 2019 at a stakeholder workgroup meeting, one of them being a project inclusive of older adults and young adults. A few months later at another stakeholder workgroup, the Executive Director for Pathways to Hope, shared an idea related to a possible intergenerational project, resulting in overall support of this project.

Shasta County receives guidance from several committees and workgroups that help guide the planning and utilization of Mental Health Services Act funding. The idea for this project was developed by the MHSA Stakeholder Workgroup, was then assessed, and unanimously supported and approved by the County's Stand Against Stigma Committee, Suicide Prevention Workgroup, and the Mental Health, Alcohol, and Drug Advisory Board. The County relies on community feedback from various demographic groups and life experiences including but not limited to:

- Individuals living with severe mental illness (SMI); families of individuals living with SMI; therapists and providers (mental health and drug/alcohol), law enforcement agencies, educators, social services agencies as well as health care organizations.

The proposed plan was posted for public comment beginning December 7, 2020 through January 6, 2021 followed by the Mental Health Board public hearing on January 6, 2021. The County's Board of Supervisors approved this project on March 2, 2021.

The Pathways to Hope for Children staff receives annual cultural competency training, and those skills will be applied in the development and implementation of all activities within this project. Further, the County will ensure that all general MHSA standards are included and present within this project: Community Collaboration, Cultural Competency, Client-Driven, Family-Driven, as well as Wellness, Recovery, and Resiliency-Focused.

Commission Level

Commission staff originally shared this project with its six stakeholder contractors and the listserv on March 8, 2021 and the final version of this project was shared on October 22, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

There were five comments received in response to the Commission sharing this plan with stakeholder contractors and the listserv. Partial comments may have been provided below; however, comments in their entirety have been provided for Commissioners and the public:

- *The above Innovation Project for Shasta County would be beneficial to both age groups – that being the older adult (50-70) as well as high school and community college students (14-20). My daughter participated in a program like this, and it is very beneficial to the teen. By creating a multifaceted program County dollar can serve a wider range of age groups including those adults that may be able to volunteer on a long-term basis. I do have a concern about compensation for the older adult volunteers and a concern about insurance coverage for the older adult volunteer since the older adult volunteers are not paid employees and could potentially incur a loss. I am also curious about the insurance coverage and what measures are in place. Would it be possible to see a sample of the insurance language used? Congratulations for partnering with Kidder Creek Ranch Camp. Perhaps this model can be used with other like-minded service providers. (Sharon Yates, Yates PM Consulting, CFLC Committee Member, April 4, 2021)*
- *I think it sounds really good. It would be so beneficial. I was going to see how their safety plans were or how much would that take from the overall projected budget? (CLCC Committee Member, received April 6, 2021)*
- *The Steinberg Institute is thrilled to support the Hope Project. This project demonstrates the definition of innovation: leveraging the strength of community to support each individual who is a member of it. The Steinberg Institute respectfully requests the support of the Commission when it comes before them. (Tara Gamboa-Eastman, The Steinberg Institute, received October 25, 2021)*
- *I like this plan for many reasons. I think this group has done a great job of presenting a complete document for consideration. This multigenerational innovation project helps Shasta County meet the needs of those in need of human contact either early in life or later in life. The innovation plan brings the young and old together. I like this because the old folks benefit from the social contact between the young folks and other old folks in the program. And the younger folks benefit from older or retired role models and mentors. This combination helps address isolation and loneliness among the elderly and provides mentorship for the youth. It gives pathways to hope by giving people a way out of their struggles. In addition, this program is evidence-based with help from the University of Oklahoma, Tulsa's Hope Research Center. Having hope is identified in this plan as being the key to success. (Jay Scoffield, United Parents – MHSOAC Contractor, received October 28, 2021)*

- *The California Youth Empowerment Network (CAYEN), a program of Mental Health America of California (MHAC), is a program led by TAY (transitional age youth; youth ages 15-26) that brings TAY expertise and leadership into behavioral health advocacy and decision-making spaces. CAYEN is grateful that the needs of teens (ages 12-18) and older adults (ages 60+) are being uplifted in this innovation project through an intergenerational approach. There are many strengths in the proposal, especially in the ways that this project aims to bring older adults into the worlds and contexts of youth, rather than limiting this engagement in the context of the adults' lives only. (California Youth Empowerment Network, received November 2, 2021)*

Learning Objectives and Evaluation:

The County's target population are for older adults (ages 60+) and teens (ages 12-18) The goal is to serve 200 youth in the first year of the project and then maintain 200 youth for the remaining four years. It is also the goal to engage 80 older adult volunteers per year. *Criteria for selecting both youth and older adults are discussed in more detail in the Innovation Section of this analysis.*

Beyond the four high-adventure activities pairing youth with older adults, the two teen centers located in Anderson and Redding will be open and available for all teens as well as older adults to facilitate engagement and meaningful interaction. All older adults volunteering will receive appropriate screening and training and older adults will be volunteering for four hours per day.

The County estimates 75 teens visit the centers each day for a total of 19,000 visits annually. Given the amount of volunteer hours provided by older adults, it is estimated that older adults will have provided more than 16,640 volunteer hours per year (total of 80 volunteers each working 4 hours per week each year of the project).

The County has identified the following learning questions that will be evaluated and will provide insight moving forward regarding sustainability of this project:

1. Does an intergenerational connection based on shared experiences and meaningful interactions increase wellbeing among older adults and teens by:
    - Improving the mental health of older adults and mitigating risky behaviors with teens?
    - Mitigating effects of Adverse Childhood Experiences with teens?
    - Reducing suicidal ideation among teens and older adults?
    - Reducing the number of teens who access the juvenile justice system?
    - Increasing hope scores among teens and older adult volunteers?
    - Decreasing self-reported isolation among seniors?
    - Increasing school attendance and school performance among teens?

The overarching goals of this project include:

- Reducing the mental health effects of isolation and loneliness among older adults
- Increasing hope among teens and older adults
- Reducing exposure of ACEs scores among teens
- Reduce suicidal ideation for teens and older adults
- Reduce the number of teens who cross the path of the criminal justice system

Pathways to Hope for Children will be working in partnership with the Tulsa's Hope Research Center located at the University of Oklahoma who will be tasked with completing the evaluation which is being provided as an in-kind donation.

Measures to evaluate outcomes will include the following:

- Children's Hope Scale self-assessment questionnaire
- Adult Hope Scale self-assessment questionnaire
- Any increase in grades of teens at school
- Any decrease in the number of law enforcement interaction among teens
- Reduction in the number of truancies at school for tens
- An increase in school engagement for teens
- Assessments for teens will be given at intake, after the high-adventure activity, and then a final assessment 60 days post high-adventure activity
- Assessments for older adults will be given during the application process before beginning their 20-hour volunteer training academy, again at the end of the high-adventure activity and a final assessment 60 days post high-adventure activity

The County may wish to consider and discuss measures to evaluate outcomes relative to older adults as most of the measures address teens within this project.

The Budget

Funding Source	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	TOTAL
Innovation Funds						$ 1,750,000.00
						$ -
						$ -
Total	$ -	$ -	$ -	$ -	$ -	$ 1,750,000.00

5 Year Budget	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	TOTAL
Personnel	$ 170,300.00	$ 170,280.00	$ 180,180.00	$ 180,180.00	$ 180,180.00	$ 881,120.00
Operating Costs	$ 168,000.00	$ 173,000.00	$ 169,000.00	$ 169,000.00	$ 169,000.00	$ 848,000.00
Non-recurring costs	$ 11,700.00	$ 6,720.00	$ 820.00	$ 820.00	$ 820.00	$ 20,880.00
Evaluation - Donated in-kind	$ -	$ -	$ -	$ -	$ -	$ -
						$ -
						$ -
Total	$ 350,000.00	$ 350,000.00	$ 350,000.00	$ 350,000.00	$ 350,000.00	$ 1,750,000.00

The County is requesting authorization to spend up to $1,750,000 in MHSA Innovation funding for this project over a period of five years.

- Personnel costs total $881,120 (50.3% of total project cost) to cover the salary, benefits, and cost of living increases for the following staff:
    - 0.20 Executive Director
    - 0.50 FTE Center Manager
    - FT Volunteer Coordinator
    - FT Teen Center Coordinator
- Operating costs total $848,000 (48.4% of total project cost) to cover the following:
    - High-adventure activities for older adults and teens
        - Includes stipends for participants to attend activities
            - Gas cards, clothing, other items if needed
    - Costs associated with activities occurring within the two teen centers
        - Art Supplies, Games, Cooking Supplies, Tutoring Materials
    - Purchase of software program licenses to allow ease of communication for all participants:
        - Apricot Data Base System – Social Solutions
        - Microsoft Office Suites
        - Adobe Creative Cloud
        - Zoom Platform
        - Survey Monkey

- Non-recurring costs total $20,880 (1.2% of total project cost) to cover the following:
    - Furniture, kitchen appliances, and desks/chairs to outfit the teen centers
- The evaluation of this project has been donated in-kind by Dr. Chan Hellman in partnership with the University of Oklahoma, Tulsa Hope Research Center. Value of evaluation is estimated to be between $15,000-$20,000.
- The County, as a result of feedback from older adults, have decided to not compensate older adult volunteers with a salary as it has been expressed that compensation would interfere with their retirement or other fixed income. Compensation will come in the form of stipends and all activities will be paid for by this project.

At the end of this project, if there is sufficient evidence from extracted data and analysis completed by the evaluation to show this project is beneficial along with continued stakeholder support, the County will likely continue this project utilizing MHSA funding from either Community Service and Supports funding or Prevention and Early Intervention funding.

Relative to reversion, the County states a portion of the funding for this project is subject to revert as of June 30, 2022.

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

References:

Parkman, K (2021); Elderly Loneliness Statistics;
https://www.consumeraffairs.com/health/elderly-loneliness-statistics.html#:~:text=%20Adults%20report%20feeling%20more%20isolated%20in%202021,Mental%20health%20disorders%3A%20Risk%20increases%20by...%20More%20

Centers for Disease Control and Prevention Website: Adverse Childhood Experiences (ACEs) – Preventing early trauma to improve adult health:
https://www.cdc.gov/vitalsigns/aces/index.html

Scott, Cody@MHSOAC

To: Reedy, Grace@MHSOAC
Subject: FW: INN PROJECT

From: [redacted]@gmail.com>
Sent: Tuesday, April 06, 2021 12:29 PM
To: Reedy, Grace@MHSOAC <Grace.Reedy@mhsoac.ca.gov>
Subject: Re: INN PROJECT

Yes I did review it. There were quite a few sent to CLCC committee members and encouraged questions and comments. I also wanted to know more. I think it sounds really good. It would be so beneficial. I was going to see how their safety plans were or how much would that take from the overall projected budget?
[redacted]

On Tue, Apr 6, 2021 at 11:40 AM Reedy, Grace@MHSOAC <Grace.Reedy@mhsoac.ca.gov> wrote:

> Do you wish to be put into contact with the County who is developing this project? We share innovation projects to solicit feedback on projects – did you get a chance to review the project proposal?

Grace Reedy

Pronouns: she|her|hers

Health Program Specialist II

Mental Health Services

Oversight & Accountability Commission

1325 J Street, Suite 1700

Sacramento, CA 95814

☎: 916.445.8723 | ✉ grace.reedy@mhsoac.ca.gov

Website: www.mhsoac.ca.gov

MHSOAC
Mental Health Services
Oversight & Accountability Commission

From: [redacted]
Sent: Tuesday, April 06, 2021 11:14 AM
To: Reedy, Grace@MHSOAC <Grace.Reedy@mhsoac.ca.gov>
Subject: Re: INN PROJECT

Hello, My apologies, Hope Park project. I just wanted to know more information.

[redacted]

On Tue, Apr 6, 2021 at 8:32 AM Reedy, Grace@MHSOAC <Grace.Reedy@mhsoac.ca.gov> wrote:

> Thank you for your comment - which project where you discussing?
>
> Get Outlook for iOS

From: [redacted]
Sent: Friday, April 2, 2021 5:41:01 AM
To: Reedy, Grace@MHSOAC <Grace.Reedy@mhsoac.ca.gov>
Subject: INN PROJECT

Hello, my comment and or question is when about would it pilot? Still new information and different medical news daily. A project like this needs more work or I am interested in more information.

[redacted]

Scott, Cody@MHSOAC

To: Reedy, Grace@MHSOAC
Subject: FW: Innovation Project Planning_Shasta County_Project Title: Hope Park

Comments/Feedback:

Good Morning Ms. Reedy,

The above Innovation Project for Shasta County would be beneficial to both age groups – that being the older adult (50-70) as well as high school and community college students (14-20).

My daughter participated in a program like this and it is very beneficial to the teen. By creating a multifaceted program County dollar can serve a wider range of age groups including those adults that may be able to volunteer on a long-term basis.

I do have a concern about compensation for the older adult volunteers and a concern about insurance coverage for the older adult volunteer since the older adult volunteers are not paid employees, and could potentially incur a loss.

I am also curious about the insurance coverage and what measures are in place. Would it be possible to see a sample of the insurance language used?

Congratulations for partnering with Kidder Creek Ranch Camp. Perhaps this model can be used with other like-minded service providers.

Comments due by: **April 4, 2021**

In Service,

Sharon R Yates
Advocate Consultant Facilitator
MHSOAC – Client Family Leadership Committee Member

View my profile on LinkedIn

To provide comment, please email the Commission at mhsoac@mhsoac.ca.gov or contact STAFF at Grace.Reedy@mhsoac.ca.gov
Please include the name of the INN Project in the Subject line.

Scott, Cody@MHSOAC

To: Reedy, Grace@MHSOAC
Subject: FW: Hope Park

From: Tara Gamboa-Eastman <tara@steinberginstitute.org>
Sent: Monday, October 25, 2021 3:49 AM
To: MHSOAC <MHSOAC@mhsoac.ca.gov>
Cc: Maggie Merritt <maggie@steinberginstitute.org>
Subject: Hope Park

Hello,

The Steinberg Institute is thrilled to support the Hope Project. This project demonstrates the definition of innovation: leveraging the strength of community to support each individual who is a member of it. The Steinberg Institute respectfully requests the support of the Commission when it comes before them.

Thank you,
Tara

Tara Gamboa-Eastman
Legislative Advocate
Steinberg Institute
Pronouns: She/Her/Hers
(c): 415-265-7484
(e): tara@steinberginstitute.org

Scott, Cody@MHSOAC

Sent: Monday, November 8, 2021 10:02 AM
To: Reedy, Grace@MHSOAC
Subject: FW: Shasta County Innovation Plan for Review

From: Jay Scoffield <jscoffield@unitedparents.org>
Sent: 28 October, 2021 08:46
To: Robancho, Lester@MHSOAC <Lester.Robancho@mhsoac.ca.gov>
Subject: RE: Shasta County Innovation Plan for Review

Best of the morning Lester.

I like this plan for many reasons.
I think this group has done a great job of presenting a complete document for consideration. This multigenerational innovation project helps Shasta County meet the needs of those in need of human contact either early in life or later in life.
The innovation plan brings the young and old together. I like this because the old folks benefit from the social contact between the young folks and other old folks in the program. And the younger folks benefit from older or retired role models and mentors. This combination helps address isolation and loneliness among the elderly and provides mentorship for the youth. It gives pathways to hope by giving people a way out of their struggles. In addition, this program is evidence-based with help from the University of Oklahoma, Tulsa's Hope Research Center. Having hope is identified in this plan as being the key to success.
Young people in this program can learn social skills from the elderly. They have a role model to help them navigate the tumultuous teen years, perhaps teach them a job skill or two. The elderly benefit from having contact with other elderly folks in the program, and they have contact with young folks, thus pulling them out of isolation and loneliness.
All the activities in this proposal reduce loneliness and depression in the elderly. And such programs also reduce Adverse Childhood Experiences. Potentially the listed activities in this report help build bonds and break down barriers
Volunteers will receive training in topics of cultural awareness, suicide awareness, mental health first aid, and how to motivate the kids with whom they are working. And, among other things, those with lived experience can help teach young people job interviewing skills and help with homework.
This innovation plan is complete, well-written has community and stakeholder input, and the topic has been researched, including looking at similar programs in other states.
I ask, but one thing to be considered. In teaching and training volunteers, can we work on or teach the art of storytelling?

Have a good day Lester.

Jay Scoffield
Policy Specialist
United Parents
391 S. Dawson Drive, 1A
Camarillo, CA 93012
805 384 1555/1080 Fax
209-604-0455 (c)
jscoffield@unitedparents.org

November 2, 2021

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1325 J St., Suite 1700
Sacramento, CA 95814

SUBJECT: CAYEN Support of Shasta Innovative Project Plan: Hope Park

The California Youth Empowerment Network (CAYEN), a program of Mental Health America of California (MHAC), is a program led by TAY (transitional age youth; youth ages 15-26) that brings TAY expertise and leadership into behavioral health advocacy and decision-making spaces. CAYEN would like to use our youth expertise & perspective to provide feedback on the Shasta County Innovative Project Plan: Hope Park.

CAYEN is grateful that the needs of teens (ages 12-18) and older adults (ages 60+) are being uplifted in this innovation project through an intergenerational approach. There are many strengths in the proposal, especially in the ways that this project aims to bring older adults into the worlds and contexts of youth, rather than limiting this engagement in the context of the adults' lives only. The proposal recognizes youth expertise and provides older adults with the opportunity to learn from them. This exchange of learning between teens and adults is crucial to building mutual respect and trust in such a program.

Furthermore, we appreciate the peer-to-peer model of pairing older adult mentors with teens who have shared lived experience, and that teens will be able to receive stipends for their involvement. Another strength in this proposal is the connection to community resources, government agencies, and cultural leaders that the Hope Park Project will have. We are happy to see relationships built with the Redding Rancheria and Teen LGBTQ Club at Anderson Teen Center, which will help the center reach more Native youth and LGBTQ youth. Additionally, we are glad to see that a goal of this teen center is to reduce the number of youth accessing the juvenile justice system, as this recognizes the need to transition youth away from carceral systems by providing broader behavioral health supports and services. The mandatory training required for volunteers and staff is also very comprehensive, and we are appreciative to see a robust cultural competency training included.

Some recommendations that we have for your consideration around this proposal are to (1) define "at-risk" youth, (2) provide clarity on how the youth and older adults will be supported through this project, and (3) to include TAY leadership where possible. The term "at-risk" is used multiple times in the proposal to describe the teens who will be served, and this term has a lot of ambiguity regarding the challenges it may be referring to. We recommend clarification of "at-risk" in the proposal to explain what group of teens you hope to reach and support through this project. This clarified definition may also provide more clarity on the types of supports and services that should be made available at the teen center.

Furthermore, the proposal describes a goal of serving 200 teens and 80 older adult volunteers each year, and that there will be 10 staff persons needed. We recommend for staff to have shared lived experience with the communities who will be reached and served. TAY can be a great age group to hire for some of these staff positions, as they can help to be a bridge between the teens and older adults through their expertise around the support systems, strengths, and challenges of youth in their community. Additionally, we advise working with teens and TAY to be a part of the planning & implementation process for the supports and services that will be available at this teen center.

Thank you for your consideration of the California Youth Empowerment Network's (CAYEN) feedback on the Shasta County Innovative Project Plan: Hope Park. CAYEN is excited to see innovative projects like these that support youth mental health, and we advocate for youth to be centered in the decision-making processes around these types of projects. Please reach out to us directly by emailing our Assistant Program Manager, Matthew Diep, at mdiep@mhac.org if you have any questions or requests related to our feedback.

In solidarity,

Matthew Diep

He/Him/Hims

Assistant Program Manager

CAYEN: California Youth Empowerment Network

mdiep@mhac.org

T: ***916-557-1167 Ext. 109***

AGENDA ITEM 4

Action

November 18, 2021 Commission Meeting

Alameda County Innovation Plan (Extension)

Summary: The Commission will consider approval of a further $4,759,312 in Innovation spending authority to support an extension to the following innovation project that was originally approved by the Commission in October 2018 for five years:

1. **Community Assessment Transport Team (CATT)**

Alameda's Community Assessment and Transport Team (CATT) proposal received Commission approval on October 25, 2018, and the project began on December 6, 2018. The CATT project is a mobile crisis unit that responds to mental health emergencies, staffed with an emergency medical technician and behavioral health clinician, in a non-emergency vehicle. The mobile crisis team serves those experiencing a mental health crisis who do not qualify for a 5150 hold and links them to services without overextending the emergency service providers, such as ambulances. The mobile response team collaborates with core service providers such as Alameda County Health Care Services and Health Care Agencies programs including Behavioral Health Care Services, Emergency Medical Services, Alameda Care Connect (Whole Person Care), 911 dispatchers, Sheriff's Office, Police Departments, and City and Human Services in a combined effort to reduce crisis transportation such as ambulances for non-crisis services.

Five CATT units are currently active throughout the County. The first three CATT units were deployed in July of 2020 in Oakland, San Leandro, and Hayward. In October of 2020 two new units were deployed in Fremont and Union City. Alameda County originally identified ten (10) cities in need of mobile crisis services indicated by the largest number of 5150 calls. As a result of the Pandemic and stay-at-home orders, some cities previously scheduled for initiating services experienced a decrease in 5150 calls and the county redirected their focus to cities affected by the pandemic with cities experiencing rising numbers of 5150 calls.

Alameda County has received Triage Grant Funding and is utilizing a portion of those funds for Mobile Crisis Teams as part of their Triage program. The Commission may wish to ask the County to describe how positions funded with Triage Grant funding differs from the positions requested through this innovation extension request.

The extension request was presented for 30-day public comment on May 17, 2021, and to stakeholders in the county's Annual Update to the Three-Year Program and Expenditure Plan FY 21-22. Alameda County also shared the extension request with community members through the 3-Year Program and Expenditure Plan FY 20-23.

As a result of this community planning process, Alameda County is requesting additional funding for the unexpected changes in contractual agreements with the Emergency Medical Transportation provider, resulting in higher pay rates than initially anticipated. Additionally, the County states there is a need to hire more Emergency Medical Technicians (EMTs) and possibly other staff including an EMS Project Coordinator. Alameda County also implemented a needed, but unexpected expansion of service regions to include Fremont and Union City.

In summary, this additional funding will be used to:

1.) Pay for salaries of Emergency Medical Technicians (EMTs):
    - Insufficient funding stems from an unexpected change in the contracted service provider, at a significantly higher rate of pay than originally negotiated with the previous provider.
    - Training and Education for EMT staff in the EMS provider recommended "Specialty Unit," to support staff in providing skilled services to consumers experiencing a mental health crisis.
2.) Help the County to respond to the immediate need of more mobile crisis teams:
    - Crucial need for additional staffing for Oakland's Mobile Crisis Team to expand to all areas of the city
    - Fremont and Union City implemented Mobile Crisis teams in October 2020, neither city was part of the original proposal as start-up cities, and unexpected funding was allocated to these two cities
3.) Help pay for an EMS' Project Coordinator
    - This position was not requested in the original proposal. The need grew from the infrastructure implementation exposing a previously unidentified need for a manager to coordinate personnel, organize and train the mobile teams, and manage the multi-region CATT project

The Commission shared the initial project with its six stakeholder contractors and other interested parties per List Serv on August 10, 2021; and the final version of the project was again shared with this same audience on September 14, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

Three comments in support of the project were received in response and are listed below – comments in their entirety have been provided in Commissioner and public packets:

"The CATT project is (sic) an important and innovative step forward in ensuring that individuals needing psychiatric services get the right care at the right time and place. We strongly support this project and the additional funding needed for its operation, which is already showing great benefits for our patients and the communities we serve" (Hospital Council of Northern and Central California)

"I like the Alameda plan. I know that in many jurisdictions, transportation issues fall to the police and 9-1-1. Which is good if it need be that way. But if they do not need police or medical, let's not have them there. As well transportation helps with outreach and treatment delivery.

And, coming from a public safety background, I always recommend transportation occur with two employees for safety reasons. I think it is a great plan this deserves our support." (Jay Scoffield, United Parents)

"I concur with the proposed Innovation Extension Request for Alameda County. By providing the additional program supports of increasing salaries to a living wage, adding extra teams to roll-on and roll-off during a crisis and most importantly adding staff and staff positions so that you can gather and provide usable information in a structured format that will give management adequate data for program metrics and program evaluation." (Sharon Yates, Yates Consulting, Client Family Leadership Committee Member)

Presenter for Alameda County's Innovation Project:
Yolanda Takahashi, Emergency Medical Services Coordinator, CATT Project Manager

Enclosures (3): (1) Biography for Alameda County's Innovation Presenter; (2) Staff Analysis: Community Assessment Transport Team (CATT); (3) Stakeholder Feedback

Handout (1): PowerPoint will be presented at the meeting

Additional Materials (1): A link to the County's Innovation Plan is available on the Commission website at the following URL:

https://mhsoac.ca.gov/wp-content/uploads/Alameda_INN_CATT-Extension-Request.pdf

Proposed Motion: The Commission approves Alameda County's Extension of their Innovation Project, as follows:

Name:	Community Assessment Transport Team (CATT)
Amount:	Up to $4,759,312 in additional MHSA Innovation funds, to a total authority of $14,637,394
Project Length:	5 Years

Alameda County
Behavioral Health Care Services

Alameda CATT Extension – Presenter Biography
Yolanda Takahashi, EMS Coordinator, PMD, and CATT Project Manager

Yolanda established her career in Emergency Medical Services (EMS) in 1994. Over the years Yolanda has held numerous jobs within the emergency medical field which included working as an Emergency Room Technician, an EMT, and a Paramedic on an 9-1-1 Ambulance for 20 years. As Yolanda's career progressed on the ambulance, she also worked as a Mental Health Paramedic, an EMS Educator, Disaster Response Team Member, and as a Shift Commander with a previous 9-1-1 Ambulance provider in Alameda County.

STAFF ANALYSIS –
Alameda County Extension

Innovative (INN) Project Name:	**Community Assessment Transportation Team (CATT)**
Extension Funding Requested for Project:	**$ 4,759,312**

Review History:

MHSOAC Original Approval Date:	October 25, 2018
Project Start Date:	December 6, 2018
Original Amount Requested:	$9,878,082
Duration of INN Project:	5 Years

Current Request:

County Submitted Innovation Extension:	September 23, 2021
Approved by BOS:	June 14, 2021
MHSOAC Consideration of INN Project:	November 18, 2021

Project Introduction:

Alameda County is requesting up to $4,759,312 in Innovation spending authority to improve mobile crisis response services by hiring additional staff, increase salaries for the emergency medical technicians/project coordinator and expansion of services to more regions of the county.

Alameda's Community Assessment and Transportation Team (CATT) proposal received Commission approval on October 25, 2018, and the project began on December 6, 2018. The CATT project is a mobile crisis unit that responds to mental health emergencies, staffed with an emergency medical technician and behavioral health clinician, in a non-emergency vehicle. The mobile crisis team serves those experiencing a mental health crisis who do not qualify for a 5150 hold and links them to services without overextending the emergency service providers, such as ambulances. The mobile response team collaborates with core service providers such as Alameda County Health Care Services and Health Care Agencies programs including Behavioral Health Care Services, Emergency Medical Services, Alameda Care Connect (Whole

Person Care), 911 dispatchers, Sheriff's Office, Police Departments, and City and Human Services in a combined effort to reduce crisis transportation such as ambulances for non-crisis services.

Five CATT units are currently active throughout the County. The first three CATT units were deployed in July of 2020 in Oakland, San Leandro, and Hayward. In October of 2020 two new units were deployed in Fremont and Union City. Alameda County originally identified ten (10) cities in need of mobile crisis services indicated by the largest number of 5150 calls. As a result of the Covid-19 pandemic and stay-at-home orders, some cities previously scheduled for initiating services experienced a decrease in 5150 calls and the county redirected their focus to cities affected by the pandemic with cities experiencing rising numbers of 5150 calls.

The Need

The County states the request for additional funding stems from unexpected changes in contractual agreements with the Emergency Medical Transportation provider, resulting in higher pay rates than initially anticipated. Additionally, the County states there is a need to hire more staff; specifically, additional Emergency Medical Technicians (EMTs) as well as the need to create a position for an EMS Project Coordinator to manage the overall project. Alameda County also implemented a needed, but unexpected expansion of service regions to include Fremont and Union City. Services began in these two areas in October 2020, though these cities were not identified in the original start-up proposal. As a result, the County is short funding to complete the project without an augmentation of Commission approved Innovation spending authority.

Additional funding approval will be used to:

1.) Pay for salaries of Emergency Medical Technicians (EMTs):
    - Insufficient funding stems from an unexpected change in the contracted service provider, at a significantly higher rate of pay than originally negotiated with the previous provider.
    - Training and Education for EMT staff in the EMS provider recommended "Specialty Unit," to support staff in providing skilled services to consumers experiencing a mental health crisis.
2.) Additional funding will help the County to respond to the immediate need of more mobile crisis teams:
    - Crucial need for additional staffing for Oakland's Mobile Crisis Team to expand to all areas of the city
    - Fremont and Union City implemented Mobile Crisis teams in October 2020, neither city was part of the original proposal as start-up cities, and unexpected funding was allocated to these two cities
3.) Additional funding of $413,373.00 will help pay for an EMS' Project Coordinator
    - This position was not requested in the original proposal. The need grew from the infrastructure implementation exposing a previously unidentified need for a

manager to coordinate personnel, organize and train the mobile teams, and manage the multi-region CATT project

The Community Program Planning (CPP) Process

Alameda County held a series of community member engagement meetings, which presented the opportunity for community members and stakeholders to provide feedback. The CPP process was conducted between June and October of 2017 and began the planning process for the initial CATT project. Five (5) community forums, 18 focus groups, and 550 surveys were completed during the engagement and plan development process.

The extension request was presented for 30-day public comment on May 17, 2021, and to stakeholders in the county's Annual Update to the Three-Year Program and Expenditure Plan FY 21-22. Alameda County also shared the extension request with community members through the 3-Year Program and Expenditure Plan FY 20-23.

Alameda County staff initially shared a version of this proposal with Commission staff May 21, 2021.

The Commission shared the initial project with its six stakeholder contractors and the list serv on August 10, 2021, and the final version of the project was again shared with stakeholders on September 14, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

Three comments in support of the project were received in response to the Commission sharing the plan with stakeholder contractors and the listserv. Comments in their entirety have been provided for Commissioners as handouts.

"The CATT project is (sic) an important and innovative step forward in ensuring that individuals needing psychiatric services get the right care at the right time and place. We strongly support this project and the additional funding needed for its operation, which is already showing great benefits for our patients and the communities we serve" (Hospital Council of Northern and Central California)

"I like the Alameda plan. I know that in many jurisdictions, transportation issues fall to the police and 9-1-1. Which is good if it need be that way. But if they do not need police or medical, let's not have them there. As well transportation helps with outreach and treatment delivery. And, coming from a public safety background, I always recommend transportation occur with two employees for safety reasons. I think it is a great plan this deserves our support." (Jay Scoffield, United Parents)

"I concur with the proposed Innovation Extension Request for Alameda County. By providing the additional program supports of increasing salaries to a living wage, adding extra teams to roll-on and roll-off during a crisis and most importantly adding staff and staff positions so that you can gather and provide usable information in a structured format that will give management

adequate data for program metrics and program evaluation." (Sharon Yates, Yates Consulting, Client Family Leadership Committee Member)

Learning Objectives and Evaluation

Alameda County is testing two primary strategies to improve the crisis system as identified in the original proposal. The County submitted the one-year evaluation report and highlights are available in the current extension request.

Testing strategies include:

1.) Create collaboration among core HCSA programs – Behavioral Health Care Services, Emergency Medical Services, and Alameda Care Connect – as well as other partners (including 911 dispatch, the County Sheriff's Office, city police departments, city health and human services, and other relevant services) to ensure the crisis response system is more agile and flexible.
2.) Combine a unique crisis transport staffing model with current technology supports to enable CATT teams to connect clients to a wider array of services in the moment.

Budget:

Alameda County is requesting an increase in Innovation spending authority of $4,759,312.

Funding Source	Funding
EMTs (Personnel/Supplies)	**$4,345,939**
EMS Project Coordinator	**$413,373**
Total Funding	**$4,759,312**

Alameda County is requesting authorization to spend up to an additional $4,759,312 in MHSA Innovation funding for the CATT extension request to complete the Commission approved five (5) year project.

The budget changes are supported with approved CATT INN funds, but without this augmentation request of additional INN funds for the reasons above, there will be insufficient INN funds to complete this project.

Additional Regulatory Requirements

The proposed project extension appears to meet the minimum requirements listed under MHSA Innovation regulations**.**

Comments

Alameda County may wish to differentiate the total funding requested for personnel expenses and the funding requested for supplies. In addition, Alameda County may wish to identify the supplies needed to complete this project.

Alameda County received Triage Grant Funding. Alameda County may wish to describe how positions funded with Triage Grant funding differs from the positions requested through this innovation extension request.

Hospital Council
Northern & Central California

August 19, 2021

Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Re: Alameda County Extension Request for the MHSA Innovation Project: Community Assessment and Transport Team (CATT)

Dear Members of the Commission:

On behalf of our hospital members in Alameda County, I am writing in support of Alameda County Behavioral Health Care Services' request for additional funding for the Community Assessment and Transport Team (CATT). This funding is vital to this pilot project's continued operation.

Currently, hospital emergency departments are experiencing high volumes due to the COVID-19 pandemic, including a significant increase in the number of patients experiencing a mental health crisis. The stress and anxiety associated with economic insecurity, social unrest, and health concerns are taking their toll. While hospital emergency departments are a safety net for people with mental health conditions and substance use disorders, they should be the option of last resort for chronic illnesses like these.

With the requested increase in funding, Alameda County will be able to continue to improve its crisis services by having a professional team respond to an individual in the course of a psychiatric emergency, assess the individual, and transport them to the most appropriate service –potentially avoiding the need for an unnecessary emergency room visit. Since the CATT launched in July, 2020, almost one third of all CATT episodes in which a client was transported resulted in a transport to a CBO provider.

The CATT project is an important and innovative step forward toward ensuring that individuals needing psychiatric services get the right care at the right time and place. We strongly support this project and the additional funding needed for its operation, which is already showing great benefits for our patients and the communities we serve.

If you have any questions regarding this letter of support, then please do not hesitate to contact me at 925-285-1696 or rrozen@hospitalcouncil.org.

Sincerely,

Rebecca Rozen

Rebecca Rozen
Regional Vice President

From:	Sharon R Yates
To:	Reedy, Grace@MHSOAC; MHSOAC
Cc:	Sharon R Yates
Subject:	Innovation Extension Request for Alameda County
Date:	Tuesday, August 24, 2021 3:55:58 PM
Attachments:	image001.gif

Good Afternoon,

I concur with the proposed Innovation Extension Request for Alameda County.

By providing the additional program supports of increasing salaries to a living wage, adding extra teams to roll-on and roll-off during a crisis and most importantly adding staff and staff positions so that you can gather and provide usable information in a structured format that will give management adequate data for program metrics and program evaluation.

In Service,
Sharon R Yates
Advocate Consultant Facilitator
MHSOAC - Client Family Leadership Committee Member

Scott, Cody@MHSOAC

Sent: Monday, November 8, 2021 10:22 AM
To: Reedy, Grace@MHSOAC
Subject: FW: Alameda innovation plan
Attachments: MHSOAC Update: Alameda County Innovation Plan Extension Request

---

From: Robancho, Lester@MHSOAC <Lester.Robancho@mhsoac.ca.gov>
Sent: Tuesday, September 28, 2021 9:03 AM
To: Jay Scoffield <jscoffield@unitedparents.org>
Cc: Reedy, Grace@MHSOAC <Grace.Reedy@mhsoac.ca.gov>
Subject: FW: Alameda innovation plan

Hi Jay,

No worries and thank you for your comments on Alameda's plan extension. I attached the original email for Alameda County—the public comment last day which is always included at towards the bottom was August 24. However we are always welcoming stakeholder comment. I am cc'ing our innovation staff who is listed in the original email for her to record and to take on any further comments.

Thanks again,

Lester Robancho *(he/his)*
Associate Governmental Program Analyst

Mental Health Services Oversight & Accountability Commission
1325 J Street, Suite 1700 Sacramento, CA 95814

916.765.2660 | lester.robancho@mhsoac.ca.gov

Mental Health Services
Oversight & Accountability Commission

From: Jay Scoffield <jscoffield@unitedparents.org>
Sent: 22 September, 2021 10:40
To: Robancho, Lester@MHSOAC <Lester.Robancho@mhsoac.ca.gov>
Subject: RE: Alameda innovation plan

Good morning Lester;

I lost the e-mail and began to worry if I had already commented on it. So, in the end, I created more work for you and me. Sorry about that.

So I will comment anyway.

I like the Alameda plan. I know that in many jurisdictions, transportation issues fall to the police and 9-1-1. Which is good if it need be that way. But if they do not need police or medical, let's not have them there. As well transportation helps with outreach and treatment delivery.

And, coming from a public safety background, I always recommend transportation occur with two employees for safety reasons.

I think it is a great plan this deserves our support.

I'm using Adobe Acrobat.

You can view "Alameda County_INN Project Plan_CATT Extension Request_9.13.2021_Final.pdf" at:
https://documentcloud.adobe.com/link/track?uri=urn:aaid:scds:US:664a9720-7c62-4e04-b1b8-b3ee6b1382f0

I'm using Adobe Acrobat.
You can view "Alameda County_INN Project Plan_CATT Extension Request_9.13.2021_Final.pdf" at:
https://documentcloud.adobe.com/link/track?uri=urn:aaid:scds:US:691f07ce-a83a-459b-9d99-ee459d967081

Jay Scoffield
Policy Specialist
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www.unitedparents.org

AGENDA ITEM 5

Action

November 18, 2021 Commission Meeting

Anti-Bullying Social Media Network

Summary: The Mental Health Services Oversight and Accountability Commission will create and support a peer social media network for children and youth, with an emphasis on students in kindergarten and grades 1 to 12 who have experienced bullying, or who are at risk of bullying based on race, ethnicity, language, or country of origin., or perceived race, ethnicity, or country of origin

Background:
The Asian Pacific Islander (API) Equity Budget authorized the Commission to allocate $5 million of its budget to create and support a peer social media network for children and youth. The goal is to develop a peer social media program of support through the delivery of trusted content from licensed therapists, counselors, or others. This Network will provide a platform for the healthy discussion of difficult topics that young people may not feel comfortable discussing with teachers or parents. The goal is to reduce risks associated with bullying and improve youth resiliency when experiencing bullying. The budget language also specified that contracts should be executed by October 31, 2021.

To inform this process, the Commission formed an Anti-Bullying Advisory Committee, led by Commissioner Chen, and contracted with Youth Leadership Institute (YLI) and Program11 to assist the Committee in developing recommendations for this program. The Committee met on three occasions between August 31, 2021 and October 30, 2021. The Committee includes 20 youth and adult allies with knowledge and experience about bullying, social media, and youth engagement strategies.

The culmination of the Committee process is a set of recommendations, priorities, and core competencies for contractors. These recommendations were developed through a process of conducting interviews, surveys and reviewing desk research, as well as robust discussion during the public Committee meetings. Triangulation of this data provided a framework of priorities for the social media strategy.

Presenters:
Anna Naify, PsyD, Consulting Psychologist
Miriam Bookey, Founder and Partner, Program11

Handouts: A Power Point presentation will be provided at the meeting.

Enclosures (2): (1) Presenter Bios; (2)Anti-Bullying Background Brief

Motion: Authorize the Executive Director, with the approval of the Anti-Bullying Advisory Committee Chair and Commission Chair, to enter into one or more contracts for up to $5 million to develop and implement an anti-bullying social media network as directed by the State Budget. The contractor(s) shall have demonstrated expertise in multicultural youth engagement, social media and website management, and youth peer-to-peer support.

Mental Health Services
Oversight & Accountability Commission

Anti-Bullying Project Outline and Authority to Execute Contracts
Presenter Biography

Miriam Bookey, Strategy Lead, Partner & Founder, Program11

Miriam is a brand strategist and agency executive with deep expertise in research, analytics, strategy, and audience journeys. Miriam's passion is helping brands find, reach, and engage niche audiences across platforms. She has worked with a range of global brands including Microsoft, ByteDance, Costco, and Clorox, and for institutions and philanthropies that include UCLA, The Bill and Melinda Gates Foundation, Roadtrip Nation, and the Ewing Marion Kauffman Foundation.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

Anti-Bullying Social Media Network

Building a Social Media Strategy to Address Hate, Bullying and Victimization based on Race, Ethnicity, Language, Culture and Country of Origin

Too many young people in California face discrimination, violence, and abuse, due to their race, ethnicity, language, culture, and country of origin. This negative treatment often is associated with bullying, hate and harassment. These experiences take a significant toll on victims and communities by impacting emotional and physical safety. No one should be subjected to bullying because of who they are, where they come from, or the bias of others.

To address the risks associated with bullying, hate speech and related behavior, and to support young people who have had these traumatic experiences, the State of California has allocated $5 million to address the rise in bullying and to combat associated risks. This investment is intended to support victims, prevent further bullying, and promote resiliency.

To effectively invest these funds, the Mental Health Services Oversight and Accountability Commission is seeking subject matter experts, community leaders, and other advisors with an emphasis on youth and young adults. These advisors will be asked to develop a proposal to respond to the threats and risks facing young people linked to bullying and hate speech. This proposal will build upon a social media foundation to reach children, youth, and young adults across the state.

Assembling an advisory group will help ensure the Commission accesses the best tools, content, and knowledge to support victims and promote prevention and resiliency. Creating community awareness and engagement around these challenges is an important strategy to ensure children, youth, and young adults know they have community support and peer allies.

FREQUENTLY ASKED QUESTIONS

In the 2021-22 State Budget, the Commission received $5 million to support an initiative to counter bullying related to race, ethnicity, language, culture, and country of origin. The law outlines specific requirements for how those funds are used, as detailed below.

One key requirement for the use of these funds is the formation of an advisory group to develop a proposal for the Commission's consideration on how best to invest these funds. Based on budget language, the Commission has identified deadlines and requirements for the advisory group to support the successful implementation of an anti-bullying strategy.

What are the deadlines?
The Commission recognizes the urgency of this work, and the budget authority establishes a strict timeline for the use of these funds.

- An advisory group must be convened by August 31, 2021.
- The Commission must enter contracts to implement a proposal by October 31, 2021.
- The Commission must spend the $5 million no later than June 30, 2023.

Who must be included in the advisory group?
The advisory group will reflect a diverse group of people who each bring important insight and perspective to this project. The group will include people with bullying expertise or experience, those who have worked with victims, organizational representatives that are addressing racial justice, health care providers, and others. The advisory group must include:

- Youth
- Transition aged youth
- Mental health providers
- Representatives of community-based organizations that work on issues associated with racial justice and understanding
- Representative of state agencies working on similar issues, such as the Department of Public Health
- Others as needed

What is the role of the Advisory Group?
The law states the advisory group is to develop a social media proposal that will deliver trusted content on how to reduce the risks associated with bullying and build resiliency among children and youth. That proposal should include:

- A social media strategy
- Compiled knowledge from within the advisory group and trusted guidance provided by mental health providers
- Recommendations for spending the $5 million: one or more contracts, one or more languages, etc.

What will be in the social media proposal?
The advisory group will determine the content of the social media strategy and can utilize many different approaches to reach an expansive audience. The proposal must be delivered statewide.

- The advisory group can determine what is included in the social media program
- Many different strategies should be considered and utilized
- The advisory group may consider creating different programs, explore various ways to deliver content, evaluate success of current services etc.

What is the overall goal of this project?

The goal of this project is to help victims of bullying and bring collective awareness to the discrimination, violence, and abuse many people face due to their race, culture, language, and country of origin.

MISCELLANEOUS ENCLOSURES

November 18, 2021 Commission Meeting

Enclosures (10):

(1) October 28, 2021 Motions Summary
(2) Evaluation Dashboard
(3) Innovation Dashboard
(4) Department of Health Care Services Revenue and Expenditure Reports Status Update
(5) Calendar of Tentative Commission Meeting Agenda Items
(6) Tentative Upcoming MHSOAC Meetings and Events
(7) Lake County Innovation Project Staff Analysis - Full-Service Partnership (FSP) Multi-County Collaborative
(8) Lake County Innovation Project Plan - Full-Service Partnership (FSP) Multi-County Collaborative
(9) Monterey County Innovation Project Staff Analysis - Residential Care Facility Incubator
(10) Monterey County Innovation Project Plan - Residential Care Facility Incubator

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
October 28, 2021

Motion #: 1

Date: October 28, 2021

Time: 9:55 AM

Motion:

The Commission approves the September 23, 2021 meeting minutes.

Commissioner making motion: Commissioner Danovitch

Commissioner seconding motion: Commission Brown

Motion carried 10 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Alvarez	☐	☐	☐	☐	☒
2. Commissioner Berrick	☒	☐	☐	☐	☐
3. Commissioner Boyd	☐	☐	☐	☒	☐
4. Commissioner Brown	☒	☐	☐	☐	☐
5. Commissioner Bunch	☐	☐	☒	☐	☐
6. Commissioner Carnevale	☒	☐	☐	☐	☐
7. Commissioner Carrillo	☐	☐	☐	☒	☐
8. Commissioner Chen	☒	☐	☐	☐	☐
9. Commissioner Cortese	☒	☐	☐	☐	☐
10. Commissioner Danovitch	☒	☐	☐	☐	☐
11. Commissioner Gordon	☒	☐	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐	☐	☐
13. Commissioner Tamplen	☒	☐	☐	☐	☐
14. Commissioner Wooton	☐	☐	☐	☒	☐
15. Vice Chair Madrigal Weiss	☐	☐	☐	☒	☐
16. Chair Ashbeck	☒	☐	☐	☐	☐

Motions Summary

Commission Meeting
October 28, 2021

Motion #: 2

Date: October 28, 2021

Time: 10:25 AM

Motion:

Authorize the Executive Director to issue the Request for Application to award federal grants and enter into contracts with eligible counties.

Commissioner making motion: Commissioner Gordon

Commissioner seconding motion: Commissioner Carnevale

Motion carried 9 yes, 0 no, and 2 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Alvarez	☐	☐	☐	☒	☐
2. Commissioner Berrick	☐	☐	☒	☐	☐
3. Commissioner Boyd	☐	☐	☐	☒	☐
4. Commissioner Brown	☒	☐	☐	☐	☐
5. Commissioner Bunch	☒	☐	☐	☐	☐
6. Commissioner Carnevale	☒	☐	☐	☐	☐
7. Commissioner Carrillo	☐	☐	☐	☒	☐
8. Commissioner Chen	☒	☐	☐	☐	☐
9. Commissioner Cortese	☒	☐	☐	☐	☐
10. Commissioner Danovitch	☒	☐	☐	☐	☐
11. Commissioner Gordon	☒	☐	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐	☐	☐
13. Commissioner Tamplen	☐	☐	☒	☐	☐
14. Commissioner Wooton	☐	☐	☐	☐	☐
15. Vice Chair Madrigal Weiss	☐	☐	☐	☐	☐
16. Chair Ashbeck	☒	☐	☐	☐	☐

Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts

New Contract: None

Total Contracts: 3

Funds Spent Since the October Commission Meeting

Contract Number	Amount
17MHSOAC073	$ 180,804.54
17MHSOAC074	$ 38,804.54
21MHSOAC023	$ 353,685.84
Total	**$ 0.00**

Contracts with Deliverable Changes

17MHSOAC073
17MHSOAC074
21MHSOAC023

Mental Health Services
Oversight & Accountability Commission

Regents of the University of California, Davis: Triage Evaluation (17MHSOAC073)

MHSOAC Staff: Kai LeMasson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: $**1,777,569.16**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed and the outcomes obtained in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No No
Data Collection and Management Report	Complete	6/15/20	No

Deliverable	Status	Due Date	Change
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21- 3/15/23	No
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21- 6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	In Progress	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Complete	7/15/21	No
Draft**s** Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, Los Angeles: Triage Evaluation (17MHSOAC074)

MHSOAC Staff: Kai LeMasson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: **$1,645,018.16**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed and the outcomes obtained in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No No
Data Collection and Management Report	Complete	6/15/20	No
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21- 3/15/23	No

Deliverable	Status	Due Date	Change
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21- 6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	In Progress	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	In Progress	7/15/21	No
Drafts Formative/Process Evaluation Final Report (a and b)	Not Started	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (21MHSOAC023)

MHSOAC Staff: Rachel Heffley

Active Dates: 07/01/21 - 06/30/24

Total Contract Amount: $5,414,545.00

Total Spent: **$353,685.84**

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities.

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Complete	09/30/21	No
Quarterly Progress Reports	In Progress	12/31/21	No
Quarterly Progress Reports	Not Started	03/31/2022	No
Quarterly Progress Reports	Not Started	06/30/2022	No
Quarterly Progress Reports	Not Started	09/30/2022	No
Quarterly Progress Reports	Not Started	12/31/2022	No
Quarterly Progress Reports	Not Started	03/31/2023	No
Quarterly Progress Reports	Not Started	06/30/2023	No

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Not Started	09/30/2023	No
Quarterly Progress Reports	Not Started	12/31/2023	No
Quarterly Progress Reports	Not Started	03/31/2024	No
Quarterly Progress Reports	Not Started	06/30/2024	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD
NOVEMBER 2021

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	2	5	**7**
Participating Counties (unduplicated)	2	5	**7**
Dollars Requested	$6,509,312	$5,782,399	**$12,291,711**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2016-2017	33	30	$68,634,435	18 (31%)
FY 2017-2018	34	33	$149,548,570	19 (32%)
FY 2018-2019	53	53	$304,098,391	32 (54%)
FY 2019-2020	28	28	$62,258,683	19 (32%)
FY 2020-2021	35	33	$84,935,894	22 (37%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2021-2022	4	4	$5,955,130	4

INNOVATION PROJECT DETAILS

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Modoc	Integrated Health Care for Individuals with SMI	$480,000	5 Years	3/2/2021	Pending
Under Review	Berkeley	Encampment Based Mobile Wellness Center	$2,802,400	5 Years	6/29/2021	Pending
Under Review	Butte	REST at Everhart Village	TBD	4 Years	9/3/2021	Pending
Under Review	Sonoma	Crossroads Diversion Housing	$2,499,999	5 Years	9/29/2021	Pending
Under Review	Kern	Mobile Clinic with Street Psychiatry	TBD	TBD	10/5/2021	Pending

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Alameda	Community Assessment Transportation Team (CATT) Extension	$4,759,312	5 Years	3/25/2021	9/13/2021
Under Final Review	Shasta	Hope Park	$1,750,000	5 Years	2/17/2021	9/3/2021

APPROVED PROJECTS (FY 21-22)			
County	Project Name	Funding Amount	Approval Date
Placer	24/7 Adult Crisis Respite Center	$2,750,000	8/26/2021
Marin	Student Wellness Ambassador Program	$1,648,000	9/23/2021
Monterey	Residential Care Facility Incubator (Planning Dollars)	$792,130	11/1/2021
Lake	Multi County FSP Collaborative	$765,000	11/2/2021

DHCS Status Chart of County RERs Received
November 18, 2021 Commission Meeting

Attached below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated November 3rd, 2021. This Status Report covers the FY 2016-17 through FY 2019-20 County RERs.

For each reporting period, the Status Report provides a date received by the Department of the County's RER and a date on which Department staff completed their "Final Review."

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. MHSOAC staff process data from County RERs for inclusion in the Fiscal Reporting Tool only after the Department determines that it has completed its Final Review. FY 2017-18 RER data has not yet been incorporated into the Fiscal Reporting Tool due to format changes.

The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2017-18 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these reports through its Fiscal Reporting Tool at http://mhsoac.ca.gov/fiscal-reporting for Reporting Years FY 2012-13 through FY 2016-17 and a data reporting page at https://mhsoac.ca.gov/resources/documents-and-reports/documents?field_county_value=All&field_component_target_id=46&year=all

On October 1, 2019, DHCS published a report detailing MHSA funds subject to reversion as of July 1, 2018, covering allocation year FY 2015-16 for large counties and 2008-09 for WET and CFTN funds, updating a July 1, 2018 report detailing funds subject to reversion for allocation years FY 2005-06 through FY 2014-15 to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). Both reports can be accessed at the following webpage:

https://www.dhcs.ca.gov/services/MH/Pages/MHSAFiscalRef.aspx

DCHS MHSA Annual Revenue and Expenditure Report Status Update

FY 2005-06 through FY 2018-19, all Counties are current

County	FY 19-20 Electronic Copy Submission Date	FY 19-20 Return to County Date	FY 19-20 Final Review Completion Date
Alameda	1/29/2021	2/1/2021	2/8/2021
Alpine	7/1/2021		10/15/2021
Amador	1/15/2021	1/15/2021	2/2/2021
Berkeley City	1/13/2021	1/13/2021	1/13/2021
Butte			
Calaveras	1/31/2021	2/1/2021	2/9/2021
Colusa	4/15/2021	4/19/2021	5/27/2021
Contra Costa	1/30/2021	2/1/2021	2/22/2021
Del Norte	2/1/2021	2/2/2021	2/17/2021
El Dorado	1/29/2021	1/29/2021	2/4/2021
Fresno	12/29/2020	12/29/2021	1/26/2021
Glenn	2/19/2021	2/24/2021	3/11/2021
Humboldt	4/9/2021	4/13/2021	4/15/2021
Imperial	2/1/2021	2/1/2021	2/12/2021
Inyo	4/1/2021	4/2/2021	
Kern	2/2/2021	2/2/2021	2/8/2021
Kings	1/4/2021	1/4/2021	3/11/2021
Lake	2/9/2021	2/9/2021	2/17/2021
Lassen	1/25/2021	1/25/2021	1/28/2021
Los Angeles	3/11/2021	3/16/2021	3/30/2021
Madera	3/29/2021	3/30/2021	4/15/2021
Marin	2/2/2021	2/2/2021	2/17/2021
Mariposa	1/29/2021	1/29/2021	3/11/2021

DHCS Status Chart of County RERs Received
November 18, 2021 Commission Meeting

County	FY 19-20 Electronic Copy Submission Date	FY 19-20 Return to County Date	FY 19-20 Final Review Completion Date
Mendocino	12/30/2020	1/4/2021	1/20/2021
Merced	1/11/2021	1/12/2021	1/15/2021
Modoc	4/29/2021	5/4/2021	5/13/2021
Mono	1/29/2021	1/29/2021	2/16/2021
Monterey	2/24/2021	3/1/2021	3/11/2021
Napa	12/23/2020	12/24/2020	12/28/2020
Nevada	1/29/2021	2/16/2021	2/18/2021
Orange	12/31/2020	1/20/2021	2/9/2021
Placer	2/3/2021	2/22/2021	2/23/2021
Plumas	2/25/2021	3/19/2021	3/25/2021
Riverside	2/1/2021	3/31/2021	4/8/2021
Sacramento	1/29/2021	2/1/2021	5/6/2021
San Benito	7/28/2021	7/30/2021	8/3/2021
San Bernardino	3/3/2021	3/4/2021	3/17/2021
San Diego	1/30/2021	2/1/2021	2/4/2021
San Francisco	1/29/2021	3/19/2021	3/22/2021
San Joaquin	2/1/2021	2/2/2021	2/11/2021
San Luis Obispo	12/31/2020	1/20/2021	1/20/2021
San Mateo	1/29/2021	2/1/2021	2/16/2021
Santa Barbara	12/29/2020	12/30/2020	1/5/2021
Santa Clara	1/28/2021	2/11/2021	3/3/2021
Santa Cruz	3/29/2021	4/5/2021	4/15/2021
Shasta	1/14/2021	1/15/2021	1/19/2021
Sierra	12/31/2020	3/10/2021	4/12/2021
Siskiyou	2/16/2021	6/11/2021	6/15/2021
Solano	2/1/2021	2/1/2021	2/25/2021

DHCS Status Chart of County RERs Received
November 18, 2021 Commission Meeting

County	FY 19-20 Electronic Copy Submission Date	FY 19-20 Return to County Date	FY 19-20 Final Review Completion Date
Sonoma	1/29/2021	3/5/2021	4/12/2021
Stanislaus	12/31/2020	1/5/2021	1/5/2021
Sutter-Yuba	1/30/2021	2/1/2021	3/9/2021
Tehama	4/27/2021	n/a	5/21/2021
Tri-City	1/27/2021	3/4/2021	3/30/2021
Trinity	2/1/2021	2/2/2021	2/17/2021
Tulare	1/26/2021	1/27/2021	2/10/2021
Tuolumne	6/2/2021	8/11/2021	8/11/2021
Ventura	1/29/2021	2/2/2021	2/16/2021
Yolo	1/28/2021	2/2/2021	2/2/2021
Total	**58**	**56**	**57**

Calendar of Tentative Commission Meeting Agenda Items

Proposed 11/18/2021

Agenda items and meeting locations are subject to change.

December 2021:

No Meeting

January 27, 2022: TBD

Mid-Year Budget Update and the Governor's Proposed Budget for 2022

The Commission will be presented with the mid-year expenditures for Fiscal Year 2021-22. The Commission will also be presented with the Governor's Proposed Budget for 2022.

Mental Health Wellness Act of 2013 (Triage) Outline and Authority to Award Grants

The Commission will be presented with an outline for the next round of Triage grants and request that the Commission delegate authority to the Executive Director to award grants to the highest scoring applicants.

Panel on Immigrant and Refugees Mental Health Needs

The Commission will hear about the gaps in services for immigrants and refugees.

February 24, 2022: TBD

Potential Innovation Plan Approval

The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Immigrant and Refugees - Stakeholder Advocacy Outline and Authority to Award Contracts

The Commission will be presented with an outline for the next round of Immigrant and Refugees Stakeholder Advocacy Contracts and request that the Commission delegate authority to the Executive Director to award contracts to the highest scoring applicants.

Legislative Priorities for 2022

The Commission will consider legislative and budget priorities for the current legislative session.

Innovation Report Out

The Commission will be presented with an update on Innovation activities.

March 24, 2022: TBD

Potential Innovation Plan Approval

The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Calendar of Tentative Commission Meeting Agenda Items

Proposed 11/18/2021

Agenda items and meeting locations are subject to change.

Legislative Priorities for 2022
The Commission will consider legislative and budget priorities for the current legislative session.

Prevention and Early Intervention Report Presentation
The Commission will consider the final report of the PEI project subcommittee for adoption.

Evaluation Committee Report Out
The Commission will hear a progress report on Triage evaluation and a progress report on the development of the MHSSA evaluation plan.

April 28, 2022: TBD

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2022
The Commission will consider legislative and budget priorities for the current legislative session.

Workplace Mental Health Report Presentation
The Commission will consider the final report of the WPMH project subcommittee for adoption.

Cultural and Linguistic Competency Committee Report Out
The Commission will hear an Update on the activities of the Cultural and Linguistic Competency Committee for 20-21.

Client and Family Leadership Committee Report Out
The Commission will hear an Update on the activities of the Client and Family Leadership Committee for 20-21.

May 26, 2022: TBD

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2022
The Commission will consider legislative and budget priorities for the current legislative session.

Governor's Budget Revisions for 2022
The Commission will be presented with the Governor's budget revisions for 2022.

Youth Drop-In Centers – allcove Grant Program Report Out
The Commission will hear an overview of progress made toward the implementation of allcove youth drop-in centers.

Early Psychosis Intervention Grant Program Report Out
The Commission will hear an overview of the progress made towards the implementation of EPI-Plus Coordinated Specialty Care Clinics.

June 2022:

No Meeting

Mental Health Services
Oversight & Accountability Commission

Tentative Upcoming MHSOAC Meetings and Events

Updated 11/5/2021

NOVEMBER 2021

- 11/10: Cultural and Linguistic Competency Committee Meeting
  - Open Meeting
  - 3:00-5:30PM

- 11/18: Commission Meeting
  - Open Meeting
  - 9:00AM-1:00PM

DECEMBER 2021

- 12/9: Client and Family Leadership Committee Meeting
  - Open Meeting
  - 1:00-3:00PM
- No Commission Meeting

JANUARY 2022

- 1/12: MHSOAC Research and Evaluation Committee Meeting
  - Open Meeting
  - 9:00AM-12:00PM

STAFF ANALYSIS –LAKE COUNTY

Innovation (INN) Project Name:	**Full-Service Partnership (FSP) Multi-County Collaborative**
Total INN Funding Requested:	**$765,000**
Duration of INN Project:	**4.5 Years**
MHSOAC consideration of INN Project:	**October 2021**

Review History:

Approved by the County Board of Supervisors:	Sept 14, 2021
Mental Health Board Hearing:	July 22, 2021
Public Comment Period:	June 22, 2021 - July 21, 2021
County submitted INN Project:	June 29, 2021
Date Project Shared with Stakeholders:	August 6 & September 3, 2021

Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):

The primary purpose of this project is to introduce a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.

This Proposed Project meets INN criteria by increasing the quality of mental health services, including measured outcomes, and promotes interagency and community collaboration related to Mental Health Servies supports or outcomes.

Project Introduction:

Lake County is requesting up to $765,000 in spending authority to join the Full-Service Partnership (FSP) Multi-County Collaborative for existing specific FSP programs, originally approved by the Commission starting with Fresno County on June 25, 2019.

What is the Problem:

Full-Service Partnerships (FSP) falls within the Community Services and Supports (CSS) component of the MHSA. Being one of the three CSS components, the FSP service is an integrated, “whatever it takes” combination of community-based, voluntary services and

strategies, built around the needs and goals of mental health consumers themselves. The core goals of these programs are to improve wellness and reduce the negative outcomes associated with severe mental illness (SMI) through active partnership between clients and their service providers.

FSPs also represents the greatest single program expenditure category and serve the populations with the highest needs in the community. Each County is required to allocate 80% of its MHSA funds to CSS programs and 51% of that is required to be specifically allocated to FSPs. Yet, despite this large expenditure for MHSA programs, there is no statewide effort to develop and implement best practices for FSP programs, and no clear model for data collection or analysis. The FSP Multi-County Collaborative will provide answers for data collection and clarity/guidelines for service programs.

The FSP Multi-County Collaborative consists of two Cohorts: Cohort one includes Fresno, Sacramento, San Mateo, San Bernardino, Siskiyou and Ventura Counties and Cohort two includes Stanislaus and Lake County. Fresno was the first County to seek approval for the FSP Multi-County Collaborative in the amount of $950,000, obtaining Commission approval on June 19, 2019. Four counties (Sacramento, San Bernardino, Siskiyou, Ventura) were approved on June 5, 2020, and Stanislaus joined on June 24, 2021, with a Commission approved contribution of $1,757,146 for a total of $5,866,415 in approved innovation funding. San Mateo County is also participating in the FSP collaborative without utilizing innovation funds, contributing to the project with CSS funding in the amount of $593,412.

The Commission contracted with Third Sector who worked collaboratively with the above Counties by administratively guiding counties through the development and implementation of this project and support the use of Innovation funds to develop the foundation for FSP service programs by utilizing data driven strategies and evaluation to better coordinate and increase quality of services and improve outcomes.

Lake County currently offers four FSP programs including Children's, Transitional Age Youth, Adult, and Older Adults, that collectively serve 120 consumers, annually. **The County has encountered difficulty developing consistent guidelines, evaluation of outcomes, and dissemination of "Best Practices." By partnering in the FSP Multi-County Collaborative efforts, the County is seeking to establish, identify, and define "clear guidelines" for offering successful treatment services to clients while maintaining the challenge of paradoxical "flexibility" to implement the "whatever it takes" model.**

Lake County proposes to invest in this FSP Innovation to improve program data sharing, program outcomes, and implementation of learnings to improve quality and inclusiveness of efficacious FSP services. The program will allow the county to evaluate current local services and their successes, while addressing uncovered challenges, and identify needs for program improvement as well as Culturally Competent inclusiveness.

How this Innovation project addresses this problem:

The Commission contracted with Third Sector who worked collaboratively with the above Counties, by administratively guiding counties through the development and implementation of this project and support the use of Innovation funds to develop the foundation for FSP service programs by utilizing data driven strategies and evaluation to better coordinate and increase quality of services and improve outcomes.

It has been over decade since the implementation of FSP programs and the County is dedicated to evaluating what is working, not working, areas in need of improvement, and inclusion of new and/or updated treatment modalities. **Lake County will work with Third Sector in collaboration with the six counties previously approved to properly identify service deficiencies, evaluate methodology, share FSP data and outcomes with the goal of collectively ensuring inclusive programmatic fidelity for all demographics and to deliver quality and robust mental health services for all FSP consumers.**

The Community Program Planning Process

Local Level

Lake County's community planning process is ongoing, and stakeholders are notified of updates and opportunities to provide input and feedback. Lake County held a virtual stakeholder meeting on April 15, 2021, which included participation from the Board of Supervisors, Behavioral Health Advisory Board, providers, community-based organizations, consumers, community members, and partners. The stakeholders acknowledged the FSP is best suited to serve the County's current needs and agreed with utilizing innovation funds as an appropriate use of funding for this project.

Commission Level

Commission staff originally shared this project with its six stakeholder contractors and the listserv on August 6, 2021, subsequent to the County completing their 30-day public comment period, and on September 3, 2021 in its final stage. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

Three comments were received in response to the Commission sharing the plan with stakeholder contractors and the listserv and are listed below. Additionally, the contractor has also provided a response in reference to the sharing of this project:

Public Comment: *"The challenge that this model specifically faces is pretty much what will make it affective or not. If there is a long-term unbalanced with data or consistent outcomes throughout the state of counties who are participating then there must be a way to compare the data in order to be successful for everyone. Is it not enough staff or inconsistent follow-ups or ? Besides that I really think the actual plan or proposal is really well presented."*

Contractor's Response: "*We completely agree that there needs to be a way to compare data across counties! That is a primary goal of this project. All of the participating counties will have ~5 outcome and process metrics that are collaboratively designed with stakeholder input and consistently defined so that we can ensure each county is measuring the same things in the same way and can understand comparative successes and opportunities for improvement. Third Sector is providing technical assistance (TA), in conjunction with the third party evaluator, to ensure that each of these metrics comes from data that all counties are able to access and will work with counties to set up any new reports or processes necessary to pull this data on a consistent basis. In addition, participating counties will set up recurring continuous improvement meetings (e.g., on a quarterly basis), where all counties will review their data together and discuss successes, challenges, best practices, and future goals.*"

Public Comment: "*I see this as a plan with lots of moving parts. It's a great plan and has my full support. Much credit to all involved with this project. To me this plan is Global in nature and takes us another step closer to understanding the vast topic of mental health. Well done!!!!!!*"

Public Comment: "I concur with the update Innovation Plans for Lake County."

Learning Objectives and Evaluation:

To guide their project; the counties have identified several learning questions that are centered on both systems-level and client level outcomes. These learning questions include:

1. What was the process that each participating county and Third Sector took to identify and refine FSP program practices?
2. What changes to counties' original FSP program practices were made and piloted?
3. Compared to current FSP program practices, do practices developed by this project streamline, simplify, and/or improve the overall usefulness of data collections and reporting for FSP programs?
4. Has this project improved how data is shared and used to inform discussions within each county on FSP program performance and strategies for continuous improvement?
5. How have the staff learnings though participation in this FSP-focused project led to shared learning across other programs and services within each participating county?
6. What was the process that participating counties and Third Sector took to create and sustain a collaborative, multi-county approach?
7. What concrete, transferrable learnings, tools, and/or recommendations for state-level change have resulted from the outcomes-driven FSP learning community and collective group of participating counties?
8. Which types of collaborative forums and topics have yielded the greatest value for county participants?
9. What impacts has this project and related changes created for clients' outcomes and clients' experiences in FSP?

Lake County's specific goals for this project also include:

1. Develop a clear strategy/for how outcome goals and performance metrics can be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Explore how appropriate goals and metric may vary based on population.
3. Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices.
4. Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning.
5. Improve existing FSP performance management practices (i.e., when, and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified).

Through participation in this project, Lake County Behavioral Health Services will have the opportunity to share and exchange knowledge with other counties participating in this project through the statewide learning community and contribute to the understanding of the unique needs of rural county populations and their systems of care.

The Budget

County	**Fresno**	**Sacramento**	**San Bernardino**	**Siskiyou**	**Ventura**	**Stanislaus**
Total INN Approved Funding	$950,000	$500,000	$979,634	$700,001	$979,634	$1,757,146
Duration of INN Project	4 Years	4.5 Years	4.5 Years	4.5 Years	4.5 Years	4.5 Years

County Lake	**INN Funding Requested**	**Local Costs for Admin and Personnel**	**Contractor/ Evaluation**	**Operating Costs**	**Non-Recurring Costs**
INN FUNDING REQUESTED	**$765,000**	$ -0-	$757,550	$7,450	$ -0-

Total					**$765,000**

Less than 1% of the budget is for Operating Cost for staff travel and in-person convenings and 99% of the budget is for the contract and evaluator expenses to cover Third Sector's technical assistance in project implementation.

Lake County is requesting authorization to spend up to $765,000 in MHSA Innovation funding for the project over a period of 4.5 years.

The proposed project appears to meet the minimum requirements listed under the MHSA Innovation regulations.

INNOVATION PROJECT PLAN

Participating Counties:

- Cohort 1: Fresno[1]; Sacramento; San Mateo[2]; San Bernardino; Siskiyou; Ventura
- Cohort 2: Stanislaus, Lake

Project Title: Multi-County Full Service Partnership (FSP) Innovation Project

Duration of Project:

- Cohort 1: January 1, 2020 through June 30, 2024 (4.5 years)
- Cohort 2: August 1, 2021 through January 30, 2026 (4.5 years)

Section 1: Innovation Regulations Requirements Categories

General Requirement: An Innovative Project must be defined by one of the following general criteria. The proposed project:

X Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention

☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population

☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system

☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose: An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

☐ Increases access to mental health services to underserved groups

X Increases the quality of mental health services, including measured outcomes

X Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes

☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

[1] Fresno County has already submitted an Innovation Project plan to the MHSOAC detailing its plans to participate in this project; this plan was approved by the MHSOAC in June 2019.

[2] San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use unspent MHSA CSS funds to participate in the goals and activities of this project, alongside other counties. These are one-time funds that have been designated and approved through a local community program planning process to meet a similar purpose and set of objectives as the Multi-County FSP Innovation Project. San Mateo County is not submitting a proposal to use INN funds but intends to participate in the broader effort and, thus, is included here and in the Multi-County FSP Innovation Project plan.

Section 2: Project Overview

Primary Challenge

Since the creation of the Mental Health Services Act (MHSA) in 2004, California has made significant strides in improving the lives of those most in need across the state. In particular, Full Service Partnerships (FSP) support people with the most severe and often co-occurring mental health needs. These MHSA-funded FSP programs are designed to apply a "whatever it takes" approach to serving and partnering with individuals living with severe mental illness. In many counties, FSP programs are effectively improving life outcomes and staff can point to success stories, highlighting dedicated staff and programs tailored to specific cultural groups and ages.

Despite the positive impact of FSP, the program has yet to reach its full potential. Many Californians with serious mental illness still struggle to achieve fuller, more independent lives and achieve the outcomes that MHSA prioritizes (i.e., reduced criminal justice involvement, incarceration, unnecessary hospitalizations, in-patient stays, and homelessness).

Counties and FSP providers have identified two barriers to improving and delivering on the "whatever it takes" promise of FSP:

The first is a *lack of information* about which components of FSP programs deliver the greatest impact. To date, several counties have strived to establish FSP programs to address specific populations and specific underserved regions, but data collection has been limited or inconsistently implemented. Additionally, there have been few coordinated efforts or comprehensive analyses of this data. This has resulted in an approach to program development that is, in its most noble of intent, driven by a desire to serve the community, but based often only on a best guess as to what will be effective. Counties desire a more data-driven approach to program development and continuous improvement, one rooted in shared metrics that paints a more complete picture of how FSP clients are faring on an ongoing basis, is closely aligned with clients' needs and goals, and allows comparison across programs, providers, and geographies. As one participating county (San Bernardino) described during an early planning meeting for this project, "Community members, FSP staff, and clinicians have identified an opportunity for data collection [and metrics] to be better integrated with assessment and therapeutic activities." These metrics might move beyond the current state-required elements and allow the actionable use of data for more effective learning and ongoing program refinement. Several counties and their provider staff, for example, indicate that FSP data is collected for state-mandated compliance and does not inform decision-making or service quality improvements. In addition, data is collected within one system, typically by FSP providers; however, meaningful FSP outcomes are designed to be measured with cross-agency data (such as health care, criminal justice, etc.), meaning many counties are reliant on self-reported progress toward outcomes rather than verified sources.

The second barrier is *inconsistent FSP implementation*. FSP's "whatever it takes" spirit has allowed necessary flexibility to adapt the FSP model for a wide variety of populations and unique local contexts. At the same time, this flexibility inhibits meaningful comparison and a unified standard of care across the state. During early planning conversations for this project, several counties indicated the need to improve how their county collects and uses FSP program data, particularly as it relates to creating

consistent and meaningful criteria for eligibility, referral, and graduation. As one participating county (San Bernardino) described, "consumers have expressed interest in a standardized format for eligibility criteria and [seek] consistency in services that are offered and/or provided." While some variation to account for local context is to be expected, standardizing these processes using data, evidence, and best practices from across California offers the promise of significant performance improvements and better client outcomes.

To-date, several initiatives have worked on related challenges but have not identified solutions that are directly applicable to this dual-natured problem, or they have not attempted to apply solutions in a statewide context. Specifically:

- While Los Angeles (LA) County's Department of Mental Health has attempted to address these two primary challenges via their FSP transformation pilot, it remains to be seen whether the metrics, strategies, and data-driven continuous improvement approach is directly applicable to other California counties, or whether their solutions need further customization and refinement in order to be used as a statewide model. Through this Multi-County FSP Innovation Project, counties will also seek to compare and leverage needs and solutions from Los Angeles County, determining how their metrics and processes can be adapted to be relevant to California counties of all geographies and sizes.

- In 2011 and 2014, the Mental Health Services Oversight and Accountability Commission (MHSOAC) supported two efforts[3] that, at a high level, worked to develop priority indicators of both consumer- and system-level mental health outcomes through leveraging existing data, develop templates and reports that would improve understanding of FSP impact on these outcomes, and identify gaps and redundancies in existing county data collection and system indicators. However, these efforts did not work to implement these changes in a collective, consistent multi-county manner, nor did they focus on additional FSP elements such as eligibility and graduation criteria. This effort also did not focus on creating actionable continuous improvement strategies that would improve the quality and consistency of FSP programs.

Proposed Project

This project responds to the aforementioned challenges by reframing FSP programs around meaningful outcomes and the partner (client) experience. This Multi-County FSP Innovation Project represents an innovative opportunity for a diverse group of participating counties (Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura) to develop and implement new data-driven strategies to better coordinate FSP service delivery, operations, data collection, and evaluation.

The MHSOAC has supported Third Sector in leading counties through the process of developing and implementing this Multi-County FSP Innovation Project, as well as in facilitating a broader statewide exchange of collective learning and shared opportunities for improving FSP programs. A San Francisco-based nonprofit, Third Sector has helped behavioral and mental health programs nationwide create an

[3] The 2011 effort was undertaken by the UCLA Center for Healthier Children, Families, and Communities and EMT Associates. The 2014 effort was undertaken by the UCLA Center for Healthier Children, Families, and Communities and Trylon.

improved focus on outcomes, guiding government agencies through the process of implementing and sustaining outcomes-oriented, data-driven services focused on improved meaningful life outcomes. *Section 4: INN Project Budget and Source of Expenditures* below further describes Third Sector's experience and approach to transitioning social services programs to an outcomes orientation. Third Sector will act as the overall project lead and project manager, developing recommendations and customized strategies, leading working group calls and collaborating with each participating county to meaningfully elevate stakeholder voice, while ensuring the project remains on schedule and adjusting responsively to any challenges.

Through participation in this Multi-County FSP Innovation Project, participating counties will implement new data-informed strategies to program design and continuous improvement for their FSP programs, supported by county-specific implementation and evaluation technical assistance. Staff will examine what matters in improving individual wellness and recovery and take a data-informed approach to program design, evaluation, and continuous improvement, leading to more effective and responsive FSP programs. The overall purpose and goals of the Multi-County FSP Innovation Project are to:

1. **Improve how counties define and track priority outcomes** and related performance measures, as well as counties' ability to apply these measures consistently across FSP programs
2. **Develop new and/or strengthen existing processes for continuous improvement** with the goals of improving outcomes, fostering shared learning and accountability, supporting meaningful program comparison, and effectively using qualitative and quantitative data to inform potential FSP program modifications
3. **Develop a clear strategy for how outcomes and performance measures can best be tracked and streamlined** through various state-level and county-specific reporting tools
4. **Develop a shared understanding and more consistent interpretation of the core FSP components** across counties, creating a common FSP framework that both reflects service design best practices and is adaptive to local context
5. **Increase the clarity and consistency of enrollment criteria, referral, and graduation processes** through the development and dissemination of clear tools and guidelines intended for county, providers, and referral partners

Collaboration with a Statewide FSP Outcomes-Driven FSP Learning Community: In addition to the county-specific implementation technical assistance (TA) proposed in this Innovation Project, counties participating in this Innovation Project have co-developed and will participate in a concurrent, statewide Outcomes-Driven FSP Learning Community that Third Sector is leading with funding from the MHSOAC. County MHSA and FSP staff, FSP providers, FSP clients, and other community stakeholders will engage in an interactive learning process that includes hearing and sharing lived experiences and developing tools to elevate FSP participant voice. Third Sector will synthesize and disseminate learnings between counties participating in this Innovation Plan and the Outcomes-Driven FSP Learning Community, helping each group build upon the work of the other, and develop a set of recommendations for any state-level changes to FSP requirements and/or data collection practices that are supported by a broad coalition of participating California counties.

Rationale for Using the Proposed Approach

Over the past several months, a broad group of counties (beyond the six counties participating in this Innovation Project) and Third Sector have convened to further unpack these challenges in a collective setting. Specifically, counties and Third Sector have collaborated in several virtual and in-person convenings to develop (i) an initial baseline understanding of counties' current FSP programs, including unique assets and challenges as it relates to defining and measuring important FSP client outcomes; data collection, data sharing, and data use; FSP services and population guidelines; and ongoing FSP performance management and continuous improvement processes, and (ii) an initial, shared plan for implementing outcomes-focused FSP improvements. Counties have expressed interest in developing a consistent and understandable framework for data collection and reporting across counties that better encourages actionable analysis of outcomes data and helps counties track the adoption of evidence-based practices.

The activities and goals proposed by this project are directly informed by these efforts and designed to respond to common challenges, capacity needs, and shared opportunities for FSP program improvements cited by counties.

This approach is also inspired by Los Angeles County Department of Mental Health's (LACDMH) journey to similarly focus their FSP programs on meaningful outcomes. This Innovation Project will build off LACDMH's early successes, implement adjusted strategies and approaches that are appropriate for a statewide context, and facilitate broader statewide exchange of collective learning and shared opportunities for improving FSP programs.

Number and Description of Population(s) Served

This project focuses on transforming the data and processes counties use to manage their FSP programs to improve performance at scale; it does not entail direct services for FSP clients. Accordingly, we have not estimated the number of individuals that will be served or identified specific subpopulations of focus. This project will build outcomes-focused approaches across a variety of age-specific and population-specific FSP programs statewide, exploring and identifying key commonalities and relevant differences by population of focus, and building a flexible, scalable set of strategies that can be further implemented statewide.

Research on the Innovative Component

This Innovation Project presents a new opportunity and innovative practice for participating counties in several ways:

1. Systems-Level Changes to Accelerate Performance

Instead of piloting a new FSP service or intervention, this project will reduce barriers that prevent counties from leveraging data and evidence to deliver better outcomes in FSP programs. While piloting and testing new service interventions remains a key tool for driving mental health services innovation, far too often promising innovations are expected to take root in systems that lack the infrastructure or capacity to support them—leading to suboptimal replication, challenges disseminating learnings, or failure to scale. This Innovation Project seeks to address those structural barriers by accelerating counties' ongoing efforts to use data and shared outcome goals to continuously improve their FSP programs, and do so in a manner that centers on increasing statewide learning.

2. County-Driven Origins with Statewide Impacts

This project also represents an opportunity for counties to drive state progress on reporting requirements, data collection, and data use. Many counties have individually struggled to track FSP client outcomes and make meaningful use of the existing data, but have to-date approached this problem alone. Recognizing these gaps and the power of a collective effort, counties themselves took the initiative to form this project as a response to their individual FSP program challenges and after hearing reflections on Los Angeles County Department of Mental Health's FSP transformation.

The county-driven origins of this project, paired with support from the MHSOAC, present a unique opportunity for participating counties to both (i) pursue county-specific implementation efforts that will drive lasting improvements within their *individual* FSP programs, and (ii) exchange learnings from these implementation efforts with other counties via a structured Outcomes-Driven FSP Learning Community designed to help increase *statewide* consensus on core FSP components and develop shared recommendations for state-level changes to FSP data requirements and guidelines.

3. Introducing New Practices for Encouraging Continuous Improvement and Learning

This project proposes to introduce new data-driven practices for managing FSP programs that center on improving clients' experiences and life outcomes and aim to increase consistency in how FSP programs are administered within and *across* different counties. It aims to develop and pilot continuous improvement processes and actionable data use strategies that are tailored to each participating county's specific context, and to generate new learning and shared consensus around FSP program and performance management best practices, alongside other participating counties. For example, a county may implement a new data dashboard that helps better illustrate client utilization of emergency services over time. This dashboard could be used to understand the relationship between an incoming client's needs, FSP services delivered, and changes in emergency services utilization over time. With this newly clarified data, county staff and/or providers would be able to understand and collaboratively discuss how different clients' needs should determine the services they receive, based on the historical success of other, similar clients.

4. Building on Individual County Progress to Create a Statewide Innovative Vision

This project will build on the continuous improvement tools and learnings emerging from Third Sector's existing work with the Los Angeles County Department of Mental Health's (LACDMH) FSP transformation, which centered on understanding and improving core FSP outcomes across all age groups, inclusive of improving stable housing, reducing emergency services utilization, and reducing criminal justice involvement. LACDMH's FSP transformation efforts have led to the development of new continuous improvement-focused "Learning Collaboratives" (regular meetings for providers and LACDMH to review outcomes data and discuss new service approaches), have surfaced new learnings and questions (e.g., how to define and measure positive FSP life outcomes like "meaningful use of time"), and have better standardized FSP programs via clarified enrollment and graduation criteria. This project presents an opportunity to deeply explore these learnings and tools at a statewide level in a collaborative manner, bringing counties together to explore and identify which FSP changes and innovations that LACDMH pursued (or purposefully did not pursue) might be most relevant and applicable across counties and, importantly, what modifications are necessary to implement these learnings at a state-level. More specifically, counties will explore how these changes may need to be adopted to meet the needs of counties with a variety of different attributes (e.g., smaller counties, more rural counties, counties with fewer program staff, counties with fewer contracted FSP programs, counties with different ethnic and racial makeups), balancing the desire for increased consistency with the spirit of meeting local context and needs.

5. Building Upon Existing Data-Focused Multi-County Collaborations

In addition, this project differs from existing, data-focused multi-county Innovation Projects in its focus on *implementing and applying* data insights to refine current learning and continuous improvement practices within FSP programs.

Four California counties are currently participating in an FSP "classification" pilot study sponsored by the MHSOAC and in partnership with the Mental Health Data Alliance. Through surveys of specific programs, this "classification" pilot seeks to identify specific components of FSP programs that are associated with high-value outcomes, namely early exits. The "classification" study can create and already has produced valuable learning on how counties can define outcomes like early exit and what FSP program characteristics map to a specified outcome. Moreover, it is an important demonstration of the value of collecting, maintaining, and sharing descriptive information about FSP program profiles that counties can correlate to FSP client outcomes.

However, the "classification" pilot does not propose to support counties in *applying* such learnings to their FSP programs, or in creating sustainable data feedback loops that leverage existing data to drive more real-time, continuous program improvements. Additionally, as a pilot, it is limited to the four participating counties and to a select few FSP programs and types (TAY, Adult, and Older Adult). Counties participating in this Multi-County FSP Innovation Project may look at the entire range of FSP services (including Child). Finally, this project will regularly connect with a larger group of counties than the scope of the "classification" pilot allows, leveraging the statewide Outcomes-Driven FSP Learning Community that is open to all counties (beyond the six counties contributing funds in this Innovation Project proposal) and that will encourage broader statewide input and collaboration.

In 2011, the UCLA Center for Healthier Children, Families, and Communities and EMT Associates, with support from the MHSOAC, developed templates and reports on statewide and county-specific data that would improve understanding of MHSA's impact, as well as evaluated existing statewide data on FSP impact. While this effort worked to identify current data collection practices and develop data templates, it did not suggest new outcomes domains, data collection, or metrics. Moreover, this effort did not focus on creating actionable continuous improvement strategies that would improve the quality and consistency of FSP programs and services.

Similarly, in 2014, the UCLA Center for Healthier Children, Families, and Communities and Trylon, with support from the MHSOAC, reviewed existing data to develop priority indicators of both consumer- and system-level mental health outcomes and understand trends and movement in these indicators over time. This effort also identified gaps and redundancies in existing county data collection and system indicators. However, it did not attempt to *implement* new and consistent outcomes and metrics across multiple counties, nor did it develop regular continuous improvement processes that would leverage these specific measures in an action-oriented, data-informed manner.

This Innovation Project will go beyond both the 2011 and 2014 UCLA-led projects by focusing on both the implementation of new data collection and data use strategies, improving consistency and clarity of program guidelines (especially those around cultural or other specific types of services, eligibility, and graduation), and better understanding the connection between FSP services and outcomes. In this manner, this proposed Multi-County FSP Innovation Project proposes a new approach by expanding the extent to which counties attempt to align and create consistency.

5. *Proposing Changes to State-level FSP Data Requirements*

Building from the above, this project also intends to surface specific data collection and data use elements that counties can use to track their FSP outcome goals in a more streamlined, consistent fashion that can be feasibly applied across the state. Through this project, counties will develop a more cohesive vision around which data elements and metrics are most relevant and recommend changes to statewide FSP data requirements that better prioritize and streamline their use. Ultimately, these recommendations will aim to better support counties in understanding who FSP serves, what services it provides, and which outcomes clients ultimately achieve.

Stakeholder Input

Through individual discussions and group convenings, Third Sector and participating counties have discussed several strategies to ensure that the Multi-County FSP Innovation Project aligns with each county's goals, including priorities expressed in stakeholder forums. The Appendix includes more detail about each county's specific stakeholder needs, how this project addresses these needs, and how community planning processes in each county have impacted the overall project vision.

To date, Third Sector has supported counties in sharing the project with local stakeholders by providing summary materials (i.e. project descriptions and talking points) and answers to frequently asked questions. These materials were requested by counties and designed to be accessible to a broad audience. Counties such as Sacramento and San Bernardino have already used and adapted these for community planning meetings, soliciting feedback that has helped to inform this plan. Currently, all

participating counties have shared this project as a part of their three-year plan, annual update, or standalone proposal for public comment and county Board of Supervisors' review.

Furthermore, this project intends to engage county stakeholders—including program participants, frontline staff, and other key community partners—throughout its duration. In the implementation stage, engagement activities may include consulting and soliciting feedback from stakeholders when defining the outcome goals, metrics, service components, and referral and graduation criteria. Counties may choose to do this through focus groups, interviews, and working group discussions. Counties may also invite participants or community representatives to participate in statewide Outcomes-Driven FSP Learning Community events. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future county meetings that are open to the public. Additional description of these activities can be found in the *Work Plan and Timeline* section below.

Learning Goals and Project Aims

This project expects to contribute new learnings and capacities for participating counties throughout the county-specific TA and evaluation activities involved. Specifically, this project will seek to assess two types of impacts: (A) the overall impact and influence of the project activities and intended changes to current FSP practices and program administration ("systems-level impacts"), and (B) the overall improvements for FSP client outcomes ("client-level impacts"). These two types of measures will help determine whether the practices developed by this project simplify and improve the usefulness of data collection and management and cross-county collaboration, and whether these practices support the project's ultimate goal of improving FSP client outcomes. Guiding evaluation questions that this project aims to explore include, but are not limited to, the following, as divided by each type of impact:

A) Systems-Level Impacts

Systems-level impacts will be assessed both within each county to understand local administration changes, as well as across counties to assess the impact of the multi-county, collaborative approach. Guiding evaluation questions to understand changes to individual county FSP administration are:

1. What was the process that each participating county and Third Sector took to identify and refine FSP program practices?
2. What changes to counties' original FSP program practices were made and piloted?
3. Compared to current FSP program practices, do practices developed by this project streamline, simplify, and/or improve the overall usefulness of data collection and reporting for FSP programs?
4. Has this project improved how data is shared and used to inform discussions within each county on FSP program performance and strategies for continuous improvement?
5. How have staff learnings through participation in this FSP-focused project led to shared learning across other programs and services within each participating county?

Beyond the above county-level learning goals, the project also aims to understand the value of a collaborative, multi-county approach via understanding the level of county collaboration, the quality of it, and its ultimate impact. Guiding evaluation questions to assess the collaborative nature of this project include, but are not limited to:

6. What was the process that participating counties and Third Sector took to create and sustain a collaborative, multi-county approach?
7. What concrete, transferrable learnings, tools, and/or recommendations for state-level change have resulted from the Outcomes-Driven FSP Learning Community and collective group of participating counties?
8. Which types of collaboration forums and topics have yielded the greatest value for county participants?

B) Client-Level Impacts

9. What impacts has this project and related changes created for clients' outcomes and clients' experiences in FSP?

Evaluation and Learning Plan

This project will include two types of learning and evaluation.

First, Third Sector and the counties will pursue a number of evaluation and data analysis activities throughout the duration of the project (as described in the *Work Plan and Timeline* section below) to better understand and measure current FSP outcomes and identify appropriate strategies for improving these outcomes.

Second, Third Sector and the California Mental Health Services Authority ("CalMHSA") will support counties in identifying, procuring, and establishing an ongoing governance structure for partnering with a third-party evaluator. This third-party evaluator ("evaluator") will provide an independent assessment of the project's impacts and meaningfully assess the above learning goals via an evaluation. These efforts will support counties in articulating a meaningful, data-informed impact story to share across the state about the specific actions pursued through this project and the resulting learnings.

Counties have expressed a desire to prioritize onboarding this evaluator in the early stages of the project. The counties have emphasized the importance of having this partner involved in any initial efforts to approximate counties' baseline FSP practices and performance, as well as provide appropriate time to execute any data-sharing agreements required for the evaluator to gather and assess outcomes data across each of the participating counties. Currently, counties have identified RAND Corporation as a potential evaluation partner, given that RAND has previously partnered with counties through CalMHSA and brings previous experience evaluating FSP programs in LA County. Participating counties, Third Sector,[4] and CalMHSA are currently taking steps to contract and onboard this evaluation partner.

A description and example measures for each of the nine evaluation questions follows below. Counties, with support from Third Sector and the evaluator, will develop and finalize these measures after contracting with the evaluator. The evaluation plan will include a timeline for defined deliverables and

[4] Third Sector will support counties in identifying and onboarding an evaluation partner, developing an ongoing governance structure for collaborating with the evaluator, and finalizing outcome measures and required data collection strategies through Third Sector's TA period (i.e., through November 2021). Third Sector does not plan to have an ongoing role in the Evaluation period (December 2021 through June 2024).

will crystallize these evaluation questions, outcome measures, data-sharing requirements and resulting evaluation activities. Evaluation planning activities will also include developing and confirming a strategy for each county to gather and collect data consistently, both for the purposes of creating a baseline understanding of current FSP program practices and performance, as well as for gathering data required for the evaluation.

The table below proposes potential qualitative and quantitative measures to assess both systems-level and client-level impacts. As described above, these system-level impacts will assess the positive value and changes experienced by participating counties and community stakeholders. These systems-level measures will be tracked during and following the initial 23-month implementation TA period, and directly answer guiding evaluation questions 1-8 above. Additionally, this project proposes to measure overall improvements in FSP client outcomes that may occur during the project timeframe (client-level impacts), to better understand evaluation question 9 above.

Example Measures	*Example Data Source*	*Relevant Evaluation Questions*
Systems-Level Impacts		
Policy changes that a county, the Department of Health Care Services (DHCS), or the MHSOAC implemented as a result of the project	Qualitative interviews of participating counties, state agencies	2, 5, 7
New FSP service approach as a result of the project	Qualitative interviews of participating counties, observational data from local FSP programs	2, 4, 5, 7
New data sharing mechanisms and/or agreements created to support ongoing evaluation, feedback, and analysis of disparities	Qualitative interviews of participating counties	3, 4, 7
Improvements or changes to FSP continuous improvement practices	Qualitative interviews of participating counties	2, 3, 4, 5, 7
New FSP metrics or data elements measured in each county	Qualitative interviews of participating counties	2, 3, 4, 5, 7
FSP metrics or data elements removed by each county due to lack of relevance or usefulness	Qualitative interviews of participating counties	2, 3, 4, 5, 7
Overall staff and clinician satisfaction with quality and impact of outcome measures selected, changes to data collection practices and service guidelines	Survey and/or qualitative interviews of participating counties	2, 3, 4, 8

	Increased confidence from staff and clinicians that measures tracked are meaningful for participants and/or are regularly reviewed and used to inform programs	Survey and/or qualitative interviews of participating counties	3, 4, 8
	Increased understanding across providers and/or county staff of how priority outcomes are defined and the corresponding data collection and reporting requirements	Survey and/or qualitative interviews of participating counties and local staff	3, 4, 8
Client- and Program Level Impacts			
	Changes in cross-system outcomes, such as:		
	Increased percentage of housing-insecure FSP clients connected with housing supports	Self-report via existing outcomes collections systems; data from local housing agencies	9
	Decreased recidivism for justice-involved FSP clients	Self-report via existing outcomes collections systems; data from local jails, and state prisons	9
	Decreased use of emergency psychiatric facilities	Self-report via existing outcomes collections systems; billing records from local hospitals via the county Mental Health Plan	9
	Increased percentage of clients engaging in recreational activities, employment, and/or other forms of meaningful use of time	Self-report via existing outcomes collections systems; additional new state and local data sharing agreements targeting tax and employment data	9
	Increased percentage of clients graduating FSP successfully	Enrollment and retention data from county FSP providers	9
	Increased program graduation rates for clients due to increased capacity (i.e., exits because clients are stable and re-integrated into the community)	Enrollment and retention data from county FSP providers	9
	Additional client-level outcomes, such as:		

	Reduced FSP outcome disparities (i.e. disparities by race, ethnicity, and language)	Comparison of pre- and post-outcomes on existing outcomes collections systems	9
	Timely access to programs and services aligned with individuals' long-term goals	FSP provider services and billing records	9
	Decreased utilization of crisis services in counties (e.g., emergency rooms, mental health, justice) due to increased emphasis on prevention and wellbeing	Data from county hospitals, jails, FSP providers	9

Note that the time period for observing and evaluating changes in outcomes and metrics may end sooner (e.g., end of 2023), so as to provide sufficient time for the evaluator to measure and synthesize evaluation findings and to share this information with counties. Third Sector, the evaluator, and participating counties will determine the exact measures and an appropriate evaluation methodology for assessing client-level impacts during the project.

Participating counties will identify and finalize these measures, data sources, and associated learning goals during the first year of the project, memorialized in a shared evaluation plan, with advisory support from Third Sector and the evaluator. As mentioned above, it will be beneficial to the overall project and the project's evaluation plan to identify and partner with an evaluator prior to finalizing the specific learning metrics, given the complex and systems-level nature of these changes. While the measures listed above are preliminary ideas and priorities identified by participating counties, Third Sector, the evaluator, and the counties will work to refine these measures in the first year of this project.

The evaluation plan will include a timeline for defined deliverables and will crystallize these evaluation questions, outcome measures, data-sharing requirements and resulting evaluation activities. Third Sector, participating counties, and the evaluator will also carefully consider and discuss strategies for mitigating possible unintended consequences when designing the evaluation and selecting measures to be tracked (e.g., any perverse incentives to graduate clients from FSP before they are ready). During the first year of the project, the evaluator and Third Sector will also support counties in identifying the appropriate method and steps to develop an accurate baseline of these measures. See the *Budget Narrative* section below for additional detail on the evaluation activities.

NOTE: Cohort 2 will adopt the same project aims, learning goals, and a similar structure for stakeholder input and evaluation.

Section 3: Additional Information for Regulatory Requirements

Contracting

Participating counties intend to contract with a technical assistance provider to support counties with project implementation activities. As described above in the *Proposed Project* section, the MHSOAC has

supported Third Sector (a San Francisco-based nonprofit) in leading counties through the process of developing and implementing this Innovation Project, as well as in facilitating a broader statewide exchange of collective learning and shared opportunities for improving FSP programs. Third Sector will act as the overall project lead and project manager, developing recommendations and customized strategies, leading working group calls and collaborating with each county to meaningfully elevate stakeholder voice, while ensuring the project remains on schedule and responding to any challenges.

Participating counties will also identify and contract with an evaluation partner during the first year of the project. The evaluation partner will support counties in designing and implementing a shared strategy for assessing the project impact.

Counties plan to contract with Third Sector and the evaluation partner through the existing Joint Powers Agreement (JPA) viaCalMHSA. The JPA sets forward specific governance standards to guide county relationships with one another, Third Sector, and the evaluator and ensure appropriate regulatory compliance. CalMHSA will also develop participation agreements with each participating county that will further memorialize these standards and CalMHSA's specific role and responsibilities in providing fiscal and contract management support to the counties. As further detailed in Section 4, counties intend to use a portion of the Multi-County FSP Innovation Project budget to pay CalMHSA for this support.

Community Program Planning

The Appendix to the Innovation Plan includes more detail about each participating county's specific stakeholder needs, how this project addresses these needs, and what the overall community planning process has involved in each county. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input throughout the duration of this project, including participation via specific focus group and stakeholder interview activities outlined in the project work plan.

Alignment with Mental Health Services Act General Standards

This project meets MHSA General Standards in the following ways:

- It is a **multi-county collaboration** between Fresno, Ventura, Sacramento, Siskiyou, San Bernardino, and San Mateo to address FSP program challenges and opportunities
- It is **client-driven**, as it seeks to reframe FSP programs around meaningful outcomes for the individual, centering on holistic client **wellness and recovery**
- It seeks to create a coordinated approach to program design and service delivery, leading to an **integrated service experience for clients and family**
- It will establish a shared understanding of the core components of FSP programs and create a common framework that reflects best practices while adapting for local context and **cultural competency**
- **Diverse stakeholders** will be meaningfully engaged throughout the development and implementation of the project

Cultural Competence and Stakeholder Involvement in Evaluation

This project intends to engage each county's stakeholders (i.e., program participants, frontline staff, other key community partners) throughout its duration, including in evaluation activities. Example engagement activities may include, but are not limited to:

- Asking for input from FSP provider staff, clients or client representatives, partner agencies, and other stakeholders (via focus groups, interviews, surveys, and/or working group discussions) as counties identify and define outcome goals, develop meaningful metrics for tracking these goals over time, identify key FSP service components, and surface opportunities to clarify and streamline referral and graduation criteria
- Sharing and reviewing data gathered and analyzed throughout this project—including in the Evaluation period—with community members to gather additional input and insight in interpreting trends
- Inviting clients and/or client representatives to participate in statewide Outcomes-Driven FSP Learning Community events
- Soliciting qualitative feedback from stakeholders on how this project has helped (or hindered) FSP service delivery in each county and opportunities for further improvement
- Sharing learnings and regular updates from this project with stakeholders at MHSA community planning meetings and county-specific stakeholder committees

Innovation Project Sustainability and Continuity of Care

This Innovation Project does not propose to provide direct services to FSP clients. Each contractor (Third Sector; the third-party evaluator; CalMHSA) will operate in an advisory or administrative capacity and will not provide services to FSP clients. Throughout project implementation, participating counties will ensure continuity of FSP services, without disruption as result of this project.

Participating counties are strongly interested in sustaining any learnings, practices, and/or new statewide collaborative structures developed through this Innovation Project that demonstrate effectiveness in meeting the project goals. The Multi-County FSP Innovation Project work plan includes dedicated time and resources for sustainability planning among counties and Third Sector throughout each phase of the project. During the first two phases of the Implementation TA period (Landscape Assessment and Implementation), Third Sector will work closely with each participating county to ensure sustainability and transition considerations are identified and prioritized in developing new strategies for implementation, and that, by the conclusion of the project, county staff have the capacity to continue any such new strategies and practices piloted through this project.

In addition, the final two months of the Implementation TA period provide additional time and dedicated focus for sustainability planning, whereby Third Sector will work with participating counties to understand the success of the changes to-date and finalize strategies to sustain and build on these new data-driven approaches. Participating counties may also partner with other counties to elevate project implementation successes in order to champion broad understanding, support, and continued resources for outcomes-focused, data-driven mental health and social services. These plans are further described below in the *Work Plan and Timeline* section). Counties will also use findings from the evaluation to

identify which specific practices or changes were most effective for achieving the different client- and systems-level impacts that the project will measure, prioritizing these for continuation in future years.

Similarly, while Third Sector will organize and facilitate the statewide Outcomes-Driven FSP Learning Community in 2020, the counties and Third Sector intend for the Learning Community to be largely county-driven and county-led. The counties and Third Sector will gather feedback on the efficacy of the Learning Community at various points throughout the first year of the project (2020) and will develop a plan for continuing prioritized activities in an ongoing fashion, whether through county-led facilitation, ongoing Third Sector support, and/or another strategy. The counties and Third Sector welcome and hope to solicit the MHSOAC's input in these conversations.

Data Use and Protection

Third Sector does not intend to request, collect, or hold client-level Personally Identifiable Information (PII) and/or Protected Health Information (PHI) during this Innovation Project. Participating counties may only provide Third Sector with de-identified and/or aggregate data related to their FSP programs. Any such de-identified and/or aggregate data provided will be stored electronically within secure file-sharing systems and made available only to employees with a valid need to access.

Should the third-party evaluator require access to individual level data and/or PII/PHI, CalMHSA, the evaluator and counties will take steps to ensure appropriate data protections are put in place and necessary data use agreements are established.

Communication and Dissemination Plan

Throughout the ideation and development of this Innovation Project, Third Sector has maintained ongoing conversation with the MHSOAC to share updates on county convenings, submit contract deliverables, solicit feedback about project decisions, discuss areas of further collaboration, and generally ensure alignment of interests, goals, and expectations. As the project progresses and moves into a phase of county-specific landscaping and implementation TA, Third Sector will continue to share regular updates, questions, and deliverables with Commission staff. These updates may include summaries of common challenges that participating counties experience on their FSP programs, from state-level data collection and reporting to performance management and continuous improvement practices. Based on these common challenges, participating counties intend to develop a set of shared recommendations for changes to state-level data requirements. Through the statewide Outcomes-Driven FSP Learning Community, these recommendations will be co-created and informed by counties across the state. Third Sector will share regular updates on Learning Community workshops and may invite Commission staff to attend select events. Additionally, Third Sector and the counties will collaborate with the MHSOAC to determine if and when presentations to the Commission may be valuable for further disseminating project learnings.

As the implementation phase of work comes to a close, Third Sector will work with participating counties to develop a plan for sustaining new outcomes-focused, data-driven strategies. This will include developing a communication plan for sharing project activities, accomplishments, and takeaways with the MHSOAC and DHCS. Third Sector will share counties' recommended revisions to state data

requirements, and it will initiate discussions about opportunities for the MHSOAC and DHCS to streamline and clarify guidelines and requirements, supporting more effective and responsive FSP programs. Third Sector will also share insights about the process itself, from Innovation Plan development to implementation TA, and reflect on the successes and challenges of these efforts, promoting a discussion about the sustainability and scalability of future Innovation Projects.

Work Plan and Timeline

Project Activities and Deliverables and Timeline

The Multi-County FSP Innovation Project will begin in January 2020 and end in June 2024 for a total project duration of 4.5 years. The project will be divided into two periods: an Implementation TA period and an Evaluation period. Throughout project implementation, counties will ensure continuity of FSP services.

In the first 23-month Implementation TA period, Third Sector will work directly with each participating county to understand each county's local FSP context and provide targeted, county-specific assistance in implementing outcomes-focused improvements. Third Sector will leverage a combination of regular (weekly to biweekly) virtual meetings or calls with counties' core project staff, regular site visits and in-person working groups, and in-person stakeholder meetings, in order to advance the project objectives. These efforts will build on learnings and tools developed in Third Sector's work with the Los Angeles County Department of Mental Health, as well as Third Sector's previous partnerships with other California and national behavioral health, human services, justice, and housing agencies. Each county will receive dedicated technical support with a combination of activities and deliverables tailored for their unique county context, while also having access to shared resources and tools applicable across all FSP programs and counties.

This Implementation TA period will be divided into three discrete phases (Landscape Assessment; Implementation; Sustainability Planning). The activities and deliverables outlined below are illustrative, as exact phase dates, content, and sequencing of deliverables will depend on each county's needs and goals. County staff and Third Sector will collaborate over the next several months to identify each county's most priority activities and goals and to create a unique scope of work to meet these needs. See ***Figure 1*** below for an illustrative Implementation TA work plan and timeline by phase.

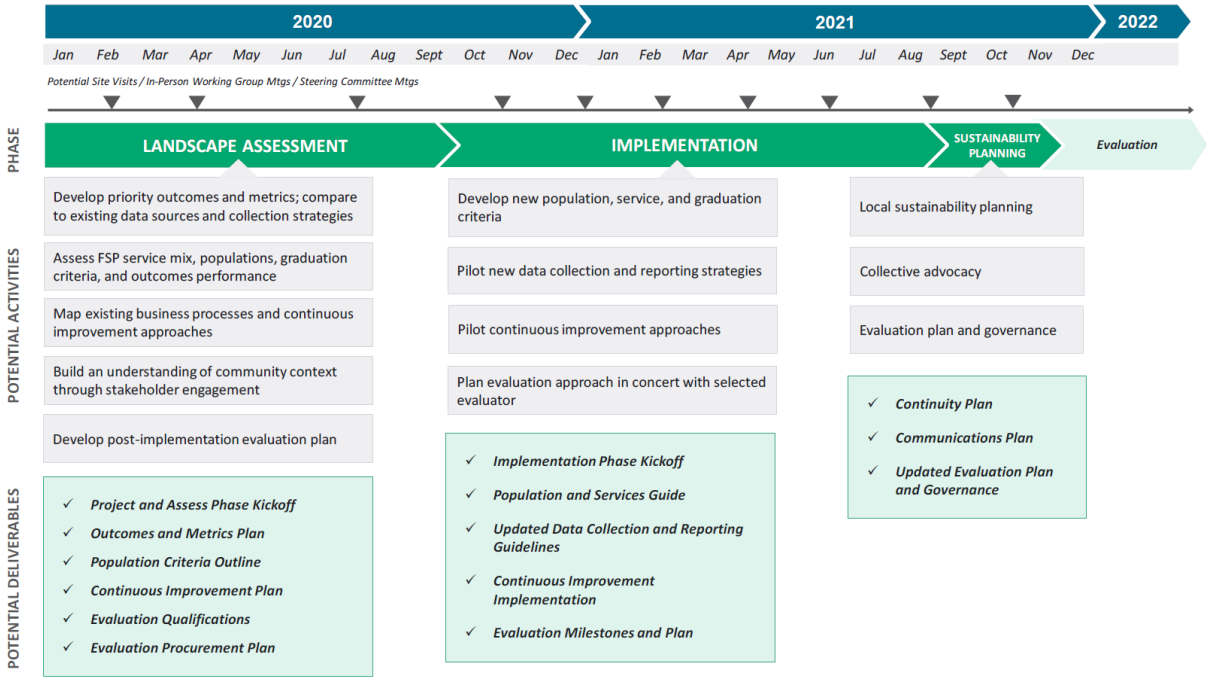
In the second period of the project, participating counties will pursue an evaluation, conducted by a third-party evaluator, with the goal of assessing the impacts and learning that this project produces.[5] This Evaluation Period and the overall Multi-County FSP Innovation Project will conclude at the end of June 2024.

NOTE: Cohort 2 will follow a parallel workplan and timeline beginning in August 2021 and ending in January 2026 [TENTATIVE]. See Appendix B for details.

[5] Note that this evaluator will also be a part of the Implementation TA period, given the importance of having this partner involved in any initial efforts to approximate counties' baseline FSP practices and performance, as well as to provide appropriate time to execute any data use agreements required for the evaluator to gather and assess outcomes data across each of the participating counties. Additional details on the timeline and plan for onboarding an evaluation partner follow in the sections below.

***Figure 1**: Cohort 1 Illustrative Implementation TA Work Plan*

***Figure 1**: Illustrative Implementation TA Work Plan*



Phase 1: Landscape Assessment

The Landscape Assessment phase will act as a ramp-up period and an opportunity for Third Sector to learn about each county's context in further detail, including local community assets, resources, and opportunities, existing FSP program practices, and performance on existing outcomes measures. Building off of templates from national mental and behavioral health projects, Third Sector will customize deliverables and activities for each county's local FSP context. During this phase, Third Sector will work with county staff to lead working groups and interviews, analyze county data, and facilitate meetings with local stakeholders to identify opportunities for improvement. County staff will share data and documents with Third Sector and provide guidance on local priorities and past experiences. Other example activities may include conducting logic models and root cause analyses to create consensus around desired FSP outcomes, reviewing current outcomes and performance data to understand trends, and gathering qualitative data about the client journey and staff challenges. By the end of this phase, each participating county will have an understanding of the current state of its FSP programs, customized recommendations to create a more data-driven, outcomes-oriented FSP program, and a realistic work plan for piloting new improvements during the Implementation phase.

Third Sector will produce a selection of the following illustrative deliverables, as appropriate for each county's unique context and needs:

- *Outcomes and Metrics Plan:* Recommended improved FSP outcomes and metrics to understand model fidelity and client success, including recommended areas of commonality, alignment, and consistency across counties
- *Population to Program Map:* A map of current FSP sub-populations, FSP programs, and community need, to illuminate any potential gaps or opportunities
- *Population Criteria Outline:* Recommended changes to population eligibility criteria, service requirements, and graduation criteria
- *Current State to Opportunity Map*: A map of metrics and existing data sources, including identification of any gaps and opportunities for improved linkages and continuity (e.g., auto-population of fields, removal of duplicate metrics, linking services or billing data to understand trends, opportunities to use additional administrative data sources to validate self-reported data)
- *Outcomes Performance Assessment*: An assessment of provider and clinic performance against preliminary performance targets, leveraging existing data and metrics
- *Process Map*: A process map identifying current continuous improvement and data-sharing processes and opportunities for improvement
- *Implementation Plan:* An implementation plan for new continuous improvement processes, both internal (i.e., creating improved feedback loops and coordination between county data, funding, and clinical or program teams) and external (i.e., creating improved feedback loops between county teams and contracted providers)

During this phase, Third Sector and the counties will develop a set of qualifications and work plan for procuring a third-party evaluator. Example evaluator-led activities and deliverables include:

- Recommended evaluation methodology (e.g., randomized control trial, quasi-experimental method, etc.)

- Work plan for executing any required data-use agreements and/or Institutional Review Board (IRB) approvals that may be necessary to implement the evaluation
- Evaluation plan that identifies specific outcomes, metrics, data sources and timeline for measuring client- and systems-level impacts
- Final impact report

Counties will select an evaluator based upon the qualifications and work plan described above. Following procurement and/or onboarding as appropriate, Third Sector, counties, and the evaluator will develop a scope of work detailing the exact deliverables and activities that the evaluator will lead as part of the evaluation, and any associated planning and preparing (e.g. validation of baseline FSP practices and performance) that should occur during the Implementation phase.

Phase 2: Implementation

Third Sector will provide individualized guidance and support to each county through the Phase 2 Implementation process, piloting new strategies that were developed during Phase 1. Understanding limitations on staff capacity, Third Sector will support county staff by preparing materials, analyzing and benchmarking performance data, helping execute on data-sharing agreements, and leading working group or project governance meetings. County staff will assist with local and internal coordination in order to meet project milestones. Additional activities in Phase 2 may include the following: improving coordination across county agencies to create a human-centered approach to client handoffs and transfers, completing data feedback loops, and developing new referral approaches for equitable access across client FSP populations. As a result of this phase, county staff will have piloted and begun implementing new outcomes-oriented, data-driven strategies.

With Third Sector's implementation support, participating counties may achieve a selection of the following deliverables in Phase 2:

- *Referral Strategies*: Piloted strategies to improve coordination with referral partners and the flow of clients through the system
- *Population and Services Guide*: New and/or revised population guidelines, service requirements, and graduation criteria
- *Updated Data Collection and Reporting Guidelines*: Streamlined data reporting and submission requirements
- *Data Dashboards:* User-friendly data dashboards displaying performance against priority FSP metrics
- *Continuous Improvement Process Implementation:* Piloted continuous improvement and business processes to create clear data feedback loops to improve services and outcomes
- *Staff Training:* Staff trained on continuous improvement best practices
- *FSP Framework:* Synthesized learnings and recommendations for the FSP framework that counties and Third Sector can share with the broader statewide Outcomes-Driven FSP Learning Community for further refinement
- *FSP Outcomes and Metrics Advocacy Packet:* Recommendations on improved FSP outcomes, metrics, and data collection and sharing practices for use in conversations and advocacy in stakeholder forums and with policy makers.

Phase 3: Sustainability Planning

Throughout Phases 1 and 2, Third Sector will work closely with each participating to ensure sustainability and transition considerations are identified and prioritized during implementation, and that, by the conclusion of the project, county staff have the capacity to continue any new strategies and practices piloted through this project. Phase 3 will provide additional time and dedicated focus for sustainability planning, whereby Third Sector will work with participating counties to understand the success of the changes to-date and finalize strategies to sustain and build on these new data-driven approaches. Participating counties may also partner with other counties to elevate project implementation successes in order to champion broad understanding, support, and continued resources for outcomes-focused, data-driven mental health and social services. Specific Phase 3 activities may include articulating lessons learned, applying lessons learned to other mental health and social service efforts, creating ongoing county work plans, and developing an FSP impact story. As a result of Phase 3, each participating county will have a clear path forward to continue building on the accomplishments of the project.

Third Sector will produce a selection of the following deliverables for each county:

- *Project Case Study:* A project case study highlighting the specific implementation approach, concrete changes, and lessons learned
- *Continuity Plan*: A continuity plan that identifies specific activities, timelines and resources required to continue to implement additional outcomes-oriented, data-driven approaches
- *Project Toolkit:* A project toolkit articulating the specific approaches and strategies that were successful in the local FSP transformation for use in similarly shifting other mental health and related services to an outcomes orientation
- *Communications Plan:* A communications strategy articulating communications activities, timelines, and messaging
- *Project Takeaways*: Summary documents articulating major takeaways for educating statewide stakeholders on the value of the new approach
- *Evaluation Work Plan and Governance:* An evaluation work plan to assist the counties and the evaluation partner in project managing the Evaluation period

Expected Outcomes

At the end of this project, each participating county will have clearly defined FSP outcome goals that relate to program and beneficiary priorities, well-defined performance measures to track progress towards these outcome goals, and a clarified strategy for tracking and sharing outcomes data to support meaningful comparison, learning, and evaluation. The specific implementation activities may vary based on the results of each county's landscape assessment, but may include the following: piloting new referral processes, updating service guidelines and graduation criteria, using qualitative and quantitative data to identify program gaps, sharing data across providers, agencies, and counties, streamlining data practices, improving data-reporting formats, implementing data-driven continuous improvement processes, and recommending changes to state-level data requirements.

Section 4: INN Project Budget and Source of Expenditures

Overview of Project Budget and Sources of Expenditures: All Counties

The total proposed budget supporting six counties in pursuing this Innovation Project is approximately $4.85M over 4.5-years. This includes project expenditures for four different primary purposes: Third Sector implementation TA ($2.87M), fiscal and contract management through CalMHSA ($.314M), third-party evaluation ($0.596M), as well as additional expenditures for county-specific needs ("County-Specific Costs") ($1.07M).

All costs will be funded using county MHSA Innovation funds, with the exception of San Mateo County which will contribute available one-time CSS funding. Counties will contribute varying levels of funding towards a collective pool of resources that will support the project expenditures (excluding County-Specific Costs, which counties will manage and administer directly). This pooled funding approach will streamline counties' funding contributions and drawdowns, reduce individual project overhead, and increase coordination across counties in the use of these funds. See ***Figure 2*** below for the estimated total sources and uses of the project budget over the 4.5-year project duration across all six participating counties. The Appendix includes additional detail on each county's specific contributions and planned expenditures.

Budget Narrative for Shared Project Costs

Consultant Costs and Contracts: Each county is contributing funding to a shared pool of resources that will support the different contractor and consultant costs associated with the project. These costs include support from Third Sector (implementation TA), CalMHSA (fiscal and contract management), and the third-party evaluator (evaluation). These consultants and contractors will operate across the group of participating counties, in addition to supporting each individual county with its own unique support needs.

The total amount of consultant and contractor costs is approximately $3.78M across all six counties over the 4.5 year timeline. A description of each of these three cost categories follows below.

Third Sector Costs

As described in the *Project Activities and Deliverables* section above, Third Sector will lead counties through individualized implementation TA over a 23-month timeframe (January 2020 through November 2021). The total budget for Third Sector's TA across all six counties is $2.87M over the full 23-month TA period. These costs will fund Third Sector teams who will provide a wide range of dedicated technical assistance services and subject matter experience to each individual county, as they pursue the goals of this Innovation Plan. Third Sector staff will leverage regular site visits to each county, in addition to leading weekly to biweekly virtual meetings with different working groups, developing recommendations for the project Steering Committee, and supporting county staff throughout each of the three implementation TA phases.

Based in San Francisco and Boston, Third Sector is one of the leading implementers of outcomes-oriented strategies in America. Third Sector has supported over 20 communities to redirect over $800M

in public funds to data-informed, outcomes-oriented services and programs. Third Sector's experience includes working with the Los Angeles County Department of Mental Health to align over $350M in annual MHSA FSP and PEI funding and services with the achievement of meaningful life outcomes for well over 25,000 Angelenos; transforming $81M in recurring mental health services in King County, WA to include new performance reporting and continuous improvement processes that enable the county and providers to better track each providers' monthly performance relative to others and against specific, county-wide performance goals; and advising the County of Santa Clara in the development of a six-year, $32M outcomes-oriented contract intended to support individuals with serious mental illness and complex needs through the provision of community-based behavioral health services.

CalMHSA Costs

Six counties (San Mateo, Sacramento, San Bernardino, Ventura, Siskiyou, and Fresno) have selected to contract using the existing Joint Powers Agreement (JPA) via CalMHSA. CalMHSA will act as the fiscal and contract manager for this shared pool of resources through the existing JPA. The JPA sets forward specific governance standards to guide county relationships with one another, Third Sector, and the evaluator. CalMHSA will develop participation agreements with each participating county that will further memorialize these standards and CalMHSA's specific role and responsibilities in providing fiscal and contract management support to the counties.

CalMHSA charges an estimated 9% for its services. Rates are based on the specific activities and responsibilities CalMHSA assumes. The total estimated cost of CalMHSA's services across all six counties, assuming a 9% rate, are $.314M over the total duration of the project.

Evaluation Costs

Third Sector and the counties will determine the appropriate procurement approach and qualifications for a third-party evaluator during the first nine months of the project. Counties have expressed a desire to prioritize onboarding an evaluator in the early stages of the project. Currently, counties have identified RAND Corporation as a potential evaluation partner, as RAND has previously partnered with counties through CalMHSA and brings previous experience evaluating FSP programs in Los Angeles County. Once selected, counties intend to contract with the evaluator via the JPA administered through CalMHSA. Third Sector and CalMHSA will support counties in determining the appropriate statement of work, budget, and funding plan for the third-party evaluator.

The current budget projects a total evaluation cost of approximately $.596M. The evaluator will be responsible for developing a formal evaluation plan, conducting evaluation activities, and producing an evaluation report. Estimated costs assume that the counties, Third Sector, and the to-be-determined third-party evaluator will collaborate to develop a uniform evaluation approach and set of performance metrics, with corresponding metric definitions that can be applied consistently across all counties. Costs are estimates and subject to change. Additional charges, such as academic overhead rates and/or the costs for completing any required data sharing agreements, may apply. If any additional information emerges that will increase costs beyond the initially budgeted amounts, the counties, CalMHSA and Third Sector will work in partnership with the MHSOAC to identify appropriate additional funding.

Budget Narrative for County-Specific Costs

The remaining project costs are intended to support additional, county-specific expenditures. Counties will fund these costs directly, rather than through a pooled funding approach. A summary of the total $1.07M in County-Specific Costs across all six counties follows below. The Appendix includes additional detail of each county's specific expenditures within these categories:

Personnel Costs

Total personnel costs (county staff salaries, benefits) for all counties are approximately $844,000 over 4.5 years and across six counties. Each county's appendix, attached, details the specific personnel that this will support.

Operating Costs

Total operating costs for counties are approximately $233,000 over 4.5 years and across six counties. Operating costs support anticipated travel costs for each county and requisite county-specific administrative costs. Each county's appendix, attached, details their specific operating costs.

Non-Recurring Costs

This project will not require any technology, equipment, or other forms of non-recurring costs.

NOTE: Cohort 2 will follow a similar budget structure. See Appendix B for details.

***Figure 2**: Cohort 1 Budget by Funding Source & Fiscal Year*

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$116,271	$181,117	$187,502	$137,735	$128,071	$750,696
2	Direct Costs	$15,454	$26,614	$27,945	$10,323	$4,700	$85,036
3	Indirect Costs	$1,409	$2,856	$2,999	$624	$624	$8,512
4	Total Personnel Costs	$133,134	$210,587	$218,446	$148,682	$133,395	$844,244
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$20,390	$24,390	$24,390	$24,390	$12,390	$105,950
6	Indirect Costs	$9,785	$29,293	$29,293	$29,293	$29,294	$126,958
7	Total Operating Costs	$30,175	$53,683	$53,683	$53,683	$41,684	$232,908
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$487,424	$1,515,954	$681,278	$186,000	$0	$2,870,655
11b	Direct Costs (CalMHSA)	$34,502	$197,029	$72,085	$6,564	$4,687	$314,866

11c	Direct Costs (3rd Party Evaluator)	$10,417	$101,649	$101,649	$196,649	$186,232	$596,596
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$532,343	$1,814,632	$855,012	$389,213	$190,919	$3,782,117
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS							
Personnel		$133,134	$210,587	$218,446	$148,682	$133,395	$844,244
Direct Costs		$552,733	$1,839,022	$879,402	$413,603	$203,309	$3,888,067
Indirect Costs		$9,785	$29,293	$29,293	$29,293	$29,294	$126,958
Total Innovation Project Budget		**$695,652**	**$2,078,902**	**$1,127,141**	**$591,578**	**$365,998**	**$4,859,269**

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1.	Innovative MHSA Funds	$621,032	$1,617,209	$899,869	$393,991	$178,828	$3,710,929
2.	Federal Financial Participation						
3.	1991 Realignment						

4.	Behavioral Health Subaccount						
5.	Other funding*	$64,203	$360,044	$125,623	$938	$938	$551,744
6.	**Total Proposed Administration**	**$685,235**	**$1,977,253**	**$1,025,492**	**$394,929**	**$179,766**	**$4,262,673**
EVALUATION:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1.	Innovative MHSA Funds	$10,417	$52,085	$52,085	$147,085	$136,668	$398,340
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	$0	$49,564	$49,564	$49,564	$49,564	$198,256
6.	**Total Proposed Evaluation**	**$10,417**	**$101,649**	**$101,649**	**$196,649**	**$186,232**	**$596,596**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1.	Innovative MHSA Funds	$631,449	$1,669,294	$951,954	$541,076	$315,496	$4,109,269
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	$64,203	$409,608	$175,187	$50,502	$50,502	$750,000
6.	**Total Proposed Expenditures**	**$695,652**	**$2,078,902**	**$1,127,141**	**$591,578**	**$365,998**	**$4,859,269**
*If "Other funding" is included, please explain.							

*San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use unspent MHSA CSS funds to participate in the goals and activities of this project, alongside other counties. Estimated amounts are provided in the table above. These are one-time funds that have been designated and approved through a local community program planning process to meet a similar purpose and set of objectives as the Multi-County FSP Innovation Project. San Mateo County is not submitting a proposal to use INN funds but is committed to participating in the broader effort and, thus, is included here and in the Multi-County FSP Innovation Project plan.

Innovation Plan Appendix A: Cohort 1

Appendix Overview

The following appendix contains specific details on the local context, local community planning process (including local review dates), and budget details for four of the six counties participating in the Multi-County FSP Innovation Project as Cohort 1:

1. Sacramento County
2. San Bernardino County
3. Siskiyou County
4. Ventura County

The other two participating counties, Fresno County and San Mateo County, are not included in this appendix for the following reasons:

5. Fresno County has already submitted an Innovation Project plan to the MHSOAC detailing its plans to participate in this project. This plan was approved by the MHSOAC.
6. San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use unspent MHSA CSS funds to participate in the goals and activities of this project, alongside other counties. These are one-time funds that have been designated and approved through a local community program planning process to meet a similar purpose and set of objectives as the Multi-County FSP Innovation Project. San Mateo County is not submitting a proposal to use INN funds but is participating in the broader effort and thus is included here.

Budget summaries for both Fresno and San Mateo, however, are included for additional reference regarding the total budget across all counties.

Each county appendix describes the county-specific local need for this Multi-County FSP Innovation Project. Though there are slight differences among participating counties' in terms of highest priority and/or specificity of local need, the response to this local need will be similar among counties through the execution of the Innovation Plan.

Through this Innovation Project proposal, participating counties seek to engage in a statewide initiative seeking to increase counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Multi-County FSP Innovation Project plan (i.e., improve how counties define and track priority outcomes, develop processes for continuous improvement, develop a clear strategy for tracking outcomes and performance measures, updating and disseminating clear FSP service guidelines, improving enrollment and referral process implementation consistency) will allow each participating county to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable participating counties to:

- Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation

- Explore how appropriate goals and metrics may vary based on population (e.g., age, acuity, etc.)
- Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices
- Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning
- Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified)

This project will also provide participating counties the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community. This learning will not only contribute to improved participant outcomes and program efficiency, but may also help facilitate statewide changes to data requirements.

In addition to outlining county-specific local need and community planning processes, each county appendix outlines a budget narrative and county budget request by fiscal year, with detail on specific budget categories.

Appendix: Sacramento County

County Contact and Specific Dates

- Primary County Contact: Julie Leung; leungj@saccounty.net; (916) 875-4044
- Date Proposal was posted for 30-day Public Review: November 18, 2019
- Date of Local Mental Health Board hearing: December 18, 2019
- Date of Board of Supervisors (BOS) approval: January 14, 2020

Description of the Local Need

Sacramento County has eight (8) FSP programs serving over 2,100 individuals annually. Each FSP serves a specific age range or focuses on a specific life domain. While a majority of the FSP programs serve transition-aged youth (18+), adults and older adults, one FSP serves older adults only, another one serves TAY only, and two serve all ages. Further, one serves Asian-Pacific Islanders, one serves pre-adjudicated youth and TAY, and two support individuals experiencing or at risk of homelessness. A new FSP serving TAY (18+), adults and older adults will be added to Sacramento County's FSP service array this fiscal year. This new FSP will utilize the evidence-based Strengths case management model.

While FSP programs provide the opportunity to better serve specific age and cultural groups who need a higher level of care, Sacramento County seeks to establish consistent FSP service guidelines, evaluate outcomes, and disseminate best practices across all FSP programs. Community members, staff, and clinicians have identified opportunities to strengthen the connection between client outcome goals and actual services received and provided by FSP programs. Providers and county department staff do not share a consistent, clear understanding of FSP service guidelines, and providers and peer agencies do not currently have a forum to meet regularly and share learnings and best practices or discuss opportunities. Overall, stakeholders would like to see FSP data used in an effective, responsive way that informs decision-making and improves service quality. Additionally, county staff would like to update inconsistent or outdated standards for referral, enrollment, and graduation.

Description of the Response to Local Need

Through this Innovation proposal, Sacramento County seeks to participate in the statewide initiative for the purpose of increasing counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan (i.e., improve how counties define and track priority outcomes, develop processes for continuous improvement, develop a clear strategy for tracking outcomes and performance measures, updating and disseminating clear FSP service guidelines, improving enrollment and referral process implementation consistency) will allow Sacramento County to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable Sacramento County to:

- Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation

- Explore how appropriate goals and metrics may vary based on population (e.g., age, acuity, life domain example: homelessness, unemployment, etc.)
- Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices
- Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning
- Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified)

In addition, this project will provide Sacramento County the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community. This learning will not only contribute to improved participant outcomes and program efficiency, but may also help facilitate statewide changes to data requirements.

Description of the Local Community Planning Process

The community planning process includes participation from the Sacramento County Mental Health Steering Act (MHSA) Steering Committee, Mental Health Board, Board of Supervisors, community based organizations, consumers and family members and community members. The community planning process helps the county determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of the community. Since this process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The Multi-County FSP Innovation Project was introduced to stakeholders at the May 16, 2019 Mental Health Services Act Steering Committee meeting. Further, at the October 17, 2019 MHSA Steering Committee meeting, the Multi-County FSP Innovation Project was presented and discussed. The Steering Committee voted in full support of Sacramento County Division of Behavioral Health Services, opting into this project with Innovation funding.

At the October 17, 2019 MHSA Steering Committee meeting, 24 committee members were in attendance and 17 public members attended. The MHSA Steering Committee is comprised of one primary member and one alternate from the following groups: Sacramento County Mental Health Board; Sacramento County's Behavioral Health Director; three (3) Service Providers (Child, Adult, and Older Adult); Law Enforcement; Adult Protective Services/Senior and Adult Services; Education; Department of Human Assistance; Alcohol and Drug Services; Cultural Competence; Child Welfare; Primary Health; Public Health; Juvenile Court; Probation; Veterans; two (2) Transition Age Youth (TAY) Consumers; two (2) Adult Consumers; two (2) Older Adult Consumers; two (2) Family Members/Caregivers of Children age 0 – 17; two (2) Family Members/Caregivers of Adults age 18 – 59; two (2) Family Members/Caregivers of Older Adults age 60+; and one (1) Consumer At-large. Some members of the committee have volunteered to represent other multiple stakeholder interests including Veterans and Faith-based/Spirituality.

The Multi-County FSP Innovation Project was posted as an attachment to the MHSA Fiscal Year 2019-20 Annual Update from November 18 through December 18, 2019. The Mental Health Board conducted a Public Hearing on December 18, 2019, beginning at 6.00 p.m. at the Grantland L. Johnson Center for

Health and Human Services located at 7001A East Parkway, Sacramento, California 95823. No public comments regarding this Innovation Project were received. The plan was presented for Board of Supervisors approval on January 14, 2020.

County Budget Narrative

Sacramento County will contribute up to $500,000 over the 4.5-year project period to support this statewide project. As of this time, Sacramento County intends to use MHSA Innovation funding subject to reversion at the end of FY19-20 for the entirety of this contribution.

As detailed below, Sacramento County will pool funding with other counties to support consultant and contracting costs. This $500,000 will support project management and technical assistance (e.g. Third Sector's technical assistance in project implementation), fiscal intermediary costs, and evaluation.

Budget and Funding Contribution by Fiscal Year and Specific Budget Category

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$0	$0	$0	$0	$0	$0
2	Direct Costs	$0	$0	$0	$0	$0	
3	Indirect Costs	$0	$0	$0	$0	$0	
4	Total Personnel Costs	$0	$0	$0	$0	$0	$0
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$0	$0	$0	$0	$0	$0
6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$0	$0	$0	$0	$0	$0

Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$48,594	$269,134	$91,990	$0	$0	$409,718
11b	Direct Costs (CalMHSA)	$5,252	$30,341	$11,147	$938	$936	$48,614
11c	Direct Costs (Evaluator)	$-	$10,417	$10,417	$10,417	$10,417	$41,668
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$53,846	$309,892	$113,554	$11,355	$11,353	$500,000
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS							
Personnel		$0	$0	$0	$0	$0	$0
Direct Costs		$53,846	$309,892	$113,554	$11,355	$11,353	$500,000

Indirect Costs	$0	$0	$0	$0	$0	$0
Total Individual County Innovation Budget*	$53,846	$309,892	$113,554	$11,355	$11,353	$500,000
CONTRIBUTION TOTALS						
Individual County Contribution	$54,849	$312,943	$114,455	$8,876	$8,876	$500,000
Additional Funding for County-Specific Project Costs	$0	$0	$0	$0	$0	$0
Total County Funding Contribution	$54,849	$312,943	$114,455	$8,876	$8,876	$500,000

Appendix: San Bernardino County

County Contact and Specific Dates

- Primary County Contacts: Francesca Michaels Francesca.michaels@dbh.sbcounty.gov, 909-252-4018; Karen Cervantes, kcervantes@dbh.sbcounty.gov, 909-252-4068
- Date Proposal was posted for 30-day Public Review: November 27, 2019
- Date of Local Mental Health Board hearing: January 2, 2020
- Calendared date to appear before Board of Supervisors: June 9, 2020

Description of the Local Need

San Bernardino County Department of Behavioral Health is dedicated to including diverse consumers, family members, stakeholders, and community members in the planning and implementation of MHSA programs and services. The community planning process helps the county determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. It empowers community members to generate ideas, contribute to decision making, and partner with the county to improve behavioral health outcomes for all San Bernardino County residents. San Bernardino is committed to incorporating best practices in the planning processes that allow consumer and stakeholder partners to participate in meaningful discussions around critical behavioral health issues. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

San Bernardino County has eight (8) FSP programs serving an estimated three thousand-four hundred-fifty-eight (3,458) individuals annually. Two (2) of these assist underserved children and youth living with serious emotional disturbance; one (1) serves Transitional Age Youth (TAY); four (4) serve adults with serious mental illness, and one (1) program specifically focuses on older adult populations. In addition to San Bernardino County FSP programs targeting specific age ranges, the programs are designed to serve unique populations such as those experiencing homelessness, who may be involved in criminal or juvenile justice, individuals transitioning from institutional care facilities, and high frequency users of emergency psychiatric services and hospitalizations, however all programs provide full wraparound services to the consumer. The specificity and number of these FSP programs are both an asset and a challenge. While they enable our county to better serve specific age, cultural, and geographic groups, our county stakeholders express the desire to establish consistency in FSP service guidelines or disseminate best practices across county regions, programs, or while transferring FSP services from one county to another. San Bernardino County intends to focus this project on Adult Full Service Partnership programs.

Through public forums, community members have identified the need for consistency in FSP services across regions, programs, and counties to better serve and stabilize consumers moving from one geographic region or program to another. Consumers have also expressed interest in a standardized format for eligibility criteria and consistency in services that are offered and/or provided. Community members, FSP staff, and clinicians have also identified an opportunity for data collection to be better integrated with assessment and therapeutic activities.

Description of the Response to Local Need

Through this Innovation proposal, San Bernardino County seeks to participate in the statewide initiative seeking to increase counties' collective capacity to gather and use data to better design, implement, and manage Adult FSP programs and services. The key priorities outlined in the Innovation Plan (i.e., improve how counties define and track priority outcomes, develop processes for continuous improvement, develop a clear strategy for tracking outcomes and performance measures, updating and disseminating clear FSP service guidelines, improving enrollment and referral process implementation consistency) will allow San Bernardino County to address current challenges and center FSP programs and services around meaningful outcomes for participants. Specifically, participating in this project and aligning with the identified priorities will enable San Bernardino County to:

- Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation
- Explore how appropriate goals and metrics may vary based on population (e.g., age, acuity, etc.)
- Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices
- Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning
- Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified

In addition, this project will provide San Bernardino County the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community. This learning will not only contribute to improved participant outcomes and program efficiency, but may also help facilitate statewide changes to data requirements.

Description of the Local Community Planning Process

The community planning process helps the county determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. The community planning process includes participation from adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests including the Board of Supervisors, and the Behavioral Health Commission. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The project was shared with stakeholders during the following:

- Community Advisory Policy Committee (CPAC), July 18, 2019
- Asian Pacific Islander Awareness Subcommittee, September 13, 2019
- Santa Fe Social Club, September 16, 2019
- African American Awareness Subcommittee, September 16, 2019
- Yucca Valley One Stop TAY Center, September 16, 2019
- Native American Awareness Subcommittee, September 17, 2019

- Transitional Age Youth (TAY) Subcommittee, September 18, 2019
- Serenity Clubhouse, September 19, 2019
- Co-Occurring and Substance Abuse Subcommittee, September 19, 2019
- Consumer and Family Member Awareness Subcommittee, September 23, 2019
- Central Valley FUN Clubhouse, September 24, 2019
- Ontario One Stop TAY Center, September 25, 2019
- Latino Awareness Subcommittee, September 26, 2019
- Older Adult Awareness Subcommittee, September 26, 2019
- A Place to Go Clubhouse, September 26, 2019
- Amazing Place Clubhouse, September 27, 2019
- Victorville One Stop TAY Center, September 27, 2019
- 2nd and 4th District Advisory Committee, October 10, 2019
- Disability Awareness Subcommittee, October 15, 2019
- 1st District Advisory Committee, October 16, 2019
- Community Advisory Policy Committee, October 17, 2019
- LGBTQ Awareness Subcommittee, October 22, 2019
- Women Awareness Subcommittee, October 23, 2019

Stakeholder feedback received was in favor of the Multi-County FSP Innovation Project with **96% of stakeholders in support** of the project, 4% neutral, and 0% opposed. A draft plan will be publicly posted for a 30-day comment period tentatively beginning on November 27, 2019. No feedback was received. The Plan was presented before the San Bernardino County Behavioral Health Commission on January 2, 2020. San Bernardino County will request Board of Supervisors review and final approval in February or March of 2020 (following the MHSOAC's review and approval process).

County Budget Narrative

San Bernardino County requests to contribute a total of $979,634 in MHSA Innovation funds to support this project over the 4.5-year project duration. This funding is not currently subject to reversion. A portion of these funds ($386,222) will cover San Bernardino County-specific expenditures, while the remainder ($593,412) will go towards the shared pool of resources that counties will use to cover shared project costs (i.e. Third Sector TA; CalMHSA; third-party evaluation):

- ***Personnel Costs:*** Costs in this category include salaries and benefits for the time spent by .10 of the Innovation Program Manager as well .5 of the Program Specialist II who will be the lead on this project. Salaries and benefits include a 3% increase to allow for cost of living increases each year. Based on current rates for administrative costs, San Bernardino County will allocate $349,272 for 4.5 years of personnel costs.
- ***Operating Costs:*** Costs in this category include travel and administrative costs that will be incurred by staff traveling to meetings for this project. Additional operating costs anticipated include printing materials for community stakeholder meetings, meeting space costs, as well as incentives to encourage stakeholder participation is consistent and ongoing. San Bernardino County anticipates operating costs, including travel, up to $36,950 over the 4.5 years, or $7,390 per year, which may vary based on the number of staff traveling and the number of in-person meetings. Costs will also vary on the number of additional stakeholder meetings held.

- ***Consultant Costs:*** The remaining amount, $588,778, will support project management and technical assistance (e.g. Third Sector's technical assistance in project implementation), fiscal intermediary costs (CalMHSA), and evaluation. The evaluation total for San Bernardino County's contribution is $41,668 or 4% of the allocated budget.

The budget totals includes 36% of the budget for personnel costs with the remaining 64% going to direct costs associated with the project including county operating costs and the consultant costs. Note that all of San Bernardino's funding contributions would come from MHSA Innovation funding. See the below tables for an estimated breakdown of budget expenditures and requested funds by fiscal year.

Budget and Funding Contribution by Fiscal Year and Specific Budget Category

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$65,787	$67,760	$69,794	$71,887	$74,044	$349,272
2	Direct Costs	$0	$0	$0	$0	$0	$0
3	Indirect Costs	$0	$0	$0	$0	$0	$0
4	Total Personnel Costs	$65,787	$67,760	$69,794	$71,887	$74,044	$349,272
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$7,390	$7,390	$7,390	$7,390	$7,390	$36,950
6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$7,390	$7,390	$7,390	$7,390	$7,390	$36,950
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0

9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$58,353	$326,706	$113,435	$0	$0	$498,494
11b	Direct Costs (CalMHSA)	$5,850	$33,338	$12,188	$938	$938	$53,250
11c	Direct Costs (Evaluator)	$0	$10,417	$10,417	$10,417	$10,417	$41,668
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$64,203	$370,461	$136,040	$11,355	$11,355	$593,412
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
EXPENDITURE TOTALS							
Personnel		$65,787	$67,760	$69,794	$71,887	$74,044	$349,272
Direct Costs		$71,593	$377,851	$143,430	$18,745	$18,745	$630,362
Indirect Costs		$0	$0	$0	$0	$0	$0
Total Individual County Innovation Budget*		$137,380	$445,611	$213,224	$90,632	$92,789	$979,634

CONTRIBUTION TOTALS						
Individual County Contribution	$64,203	$370,461	$136,040	$11,355	$11,355	$593,412
Additional Funding for County-Specific Project Costs	$73,177	$75,150	$77,184	$79,277	$81,434	$386,222
Total County Funding Contribution	$137,380	$445,611	$213,224	$90,632	$92,789	$979,634

Appendix: Siskiyou County

County Contact and Specific Dates

The primary contact for Siskiyou County is:

Camy Rightmier
Email: crightmier@co.siskiyou.ca.us
Tel: 530-841-4281

Siskiyou County's local review dates are listed in the table below. More detail on Siskiyou's stakeholder engagement process can be found in the "Local Community Planning Process" section.

Local Review Process	Date
Innovation Plan posted for 30-day Public Review	December 10, 2019
Local Mental Health Board Hearing	January 21, 2020
Board of Supervisors (BOS) approval	February 4, 2020

Description of Local Need

Siskiyou County operates two FSP programs, a Children's System of Care (CSOC) and an Adult System of Care (ASOC) program that combined serve approximately 230 individuals annually. Program eligibility is determined by diagnosis and risk factors pursuant to the MHSA regulations for FSP criteria. Each Partner is assigned a clinician and case manager that work in the appropriate system of care as determined by the Partner's age. FSP programs may also receive psychiatric services and/or peer support services upon referral by the primary service provider. Many Partners also receive services through the county Wellness Center.

Due to the specificity and flexibility of the FSP program, the county has encountered difficulty developing consistent FSP service guidelines, evaluating outcomes, and disseminating best practices. Siskiyou County utilizes the Data Collection Reporting (DCR) database developed by the State to track outcomes, however, this tool has not been useful with regard to informing treatment or promoting quality improvements.

Community stakeholders have consistently identified the need for clear, consistent and reliable data and outcomes to assist programs in identifying goals, measuring success and pinpointing areas that may need improvement. Throughout numerous focus groups where outcomes have been shared, the Department has recognized that consumers are not interested in the measurement of progress, rather they are solely focused on the amelioration of the problem. Therefore, Siskiyou County Behavioral

Health rarely receives feedback on outcome data and is evaluating the program in order to find a meaningful way in which to share the data that will encourage collaborative feedback.

Conversations with Siskiyou County FSP staff and clinicians have revealed that outcome goals and metrics are not regularly reassessed or informed by community input, nor are they well-connected to actual services received and provided by FSP programs. There is not a shared, clear understanding of FSP service guidelines among providers and county department staff, and interpretation and implementation of these guidelines varies widely. Data is collected for compliance and does not inform decision-making or service quality improvements, and data is collected within one system, with limited knowledge of cross-agency outcomes. Further, standards for referral, enrollment, and graduation are inconsistent, outdated, or non-existent.

Response to Local Need

Through this Innovation proposal, Siskiyou County Behavioral Health seeks to participate in the statewide initiative to increase counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan will allow Siskiyou County Behavioral Health to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable the department to:

1. Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Explore how appropriate goals and metrics may vary based on population.
3. Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices.
4. Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning.
5. Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified).

In addition, this project will provide Siskiyou County Behavioral Health the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community.

Local Community Planning Process

The community planning process helps Siskiyou County determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. The community planning process includes participation from the Board of Supervisors, Behavioral Health Board, providers, consumers, community members and partners. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The project was shared in stakeholder groups in March 2019, where the proposed use of Innovation funds was well-received. A draft plan was posted for a 30-day comment period beginning on December

10, 2019. No comments were received during the public comment period. Siskiyou presented this plan at a public hearing with the local mental health board on January 21, 2020. Siskiyou County submitted a final plan (incorporating any additional feedback received) to its Board of Supervisors for review and approval on February 4, 2020.

County Budget Narrative

Siskiyou County will contribute up to $700,000 of MHSA Innovation Funds over the 4.5-year project period to support this statewide project. As of this time, Siskiyou County does not intend to use funding subject to reversion for this contribution. As detailed below, Siskiyou County will pool most of this funding with other counties to support consultant and contracting costs, with a small portion of Siskiyou County's funding also set aside for county staff travel and administrative costs:

- *County Travel and Administrative Costs*: Siskiyou County anticipates travel costs up to $16,000 over the 4.5 years, or approximately $3,500 per year, which may vary based on the number of staff traveling and the number of in-person convenings. Including estimated administrative costs, Siskiyou County will allocate approximately $178,000 for 4.5 years of personnel costs.
- *Shared Project Costs*: The remaining amount, $506,000, will support project management and technical assistance (e.g. Third Sector's technical assistance in project implementation), fiscal intermediary costs, and third-party evaluation support

Siskiyou County Budget Request and Expenditures by Fiscal Year

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$17,578	$35,616	$37,396	$7,771	$7,771	$106,132
2	Direct Costs	$10,597	$21,514	$22,590	$4,700	$4,700	$64,101
3	Indirect Costs	$1,409	$2,856	$2,999	$624	$624	$8,512
4	Total Personnel Costs	$29,584	$59,986	$62,985	$13,095	$13,095	$178,745
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**Total**
5	Direct Costs	$2,000	$4,000	$4,000	$4,000	$2,000	$16,000

6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$2,000	$4,000	$4,000	$4,000	$2,000	$16,000
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)*	$58,353	$100,000	$61,983	$0	$0	$220,336
11b	Direct Costs (CalMHSA)	$5,850	$33,338	$12,188	$938	$938	$53,252
11c	Direct Costs (Evaluator)	$0	$10,417	$10,417	$105,417	$105,417	$231,668
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$64,203	$143,755	$84,588	$106,355	$106,355	$505,256
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0

EXPENDITURE TOTALS						
Personnel	$29,584	$59,986	$62,985	$13,095	$13,095	$178,745
Direct Costs	$64,203	$143,755	$84,588	$106,355	$106,355	$505,256
Indirect Costs	$2,000	$4,000	$4,000	$4,000	$2,000	$16,000
Total Individual County Innovation Budget*	$95,787	$207,741	$151,573	$123,450	$121,450	$700,001
CONTRIBUTION TOTALS						
Individual County Contribution	$64,203	$143,755	$84,588	$106,355	$106,355	$505,256
Additional Funding for County-Specific Project Costs	$31,584	$63,986	$66,985	$17,095	$15,095	$194,745
Total County Funding Contribution	$95,787	$207,741	$151,573	$123,450	$121,450	$700,001

* Third Sector will provide additional support and capacity to Siskiyou County, beyond the amount Siskiyou is able to contribute using county Innovation dollars alone. This is intended to support the objectives of Third Sector's contract with the Commission, i.e. that this Multi-County FSP Innovation Project make effort to support and provide meaningful capacity to counties with limited financial resources to participate in the project.

Appendix: Ventura County

County Contact and Specific Dates

The primary contacts for Ventura County are:

Kiran Sahota
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Tel: (805) 981-2262

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Ventura County's local review dates are listed in the table below. More detail on Ventura's stakeholder engagement process can be found in the "Local Community Planning Process" section.

Local Review Process	Date
Innovation Plan posted for 30-day Public Review	December 17, 2019
Local Mental Health Board Hearing	January 27, 2020
Board of Supervisors (BOS) approval	March 10, 2020

Description of Local Need

Ventura County has 7 FSP programs serving 619 individuals in the 2018/19 fiscal year. Each of these programs has a specific focus, yet they overlap in the age groupings as compared to age groupings as prescribed by MHSA regulations. One (1) of these serves juveniles currently on probation, 1 of these programs serves transition age youth, 4 serve adults age 18 years and older, and another serves older adults. The majority of these programs focus on individuals who are currently experiencing or at risk of experiencing incarceration, substance abuse, or homelessness. Eligibility is determined by the following factors: experience or at risk of incarceration, substance abuse, homelessness, hospitalization, or removal from the home, as well as the individual's age and a case manager or clinician recommendation.

The specificity and number of these FSP programs is both an asset and a challenge. While they enable our county to better serve specific age, cultural, and geographical groups, our county often struggles to establish consistent FSP service guidelines, evaluate outcomes, or disseminate best practices.

A common, recurring theme at community engagement gatherings has resonated toward offering more concentrated care for the seriously and persistently mentally ill homeless population. Along this line, Ventura County conducted a Mental Health Needs Assessment recently that indicated a need to address issues of homelessness and dual diagnosis as priority populations. Ventura County FSP services are fewer for those under 18 years of age and with respect to ethnicity. There has been consistent

communication in Santa Paula and Oxnard community meetings to stress the need to increase services in breadth and depth to the Latinx community. A more cohesive suite of services for step up and step down crisis aversion. To this end, Ventura County has opened up two Crisis Stabilization Units in the past two years however the feedback continues to be that there is need for more to be done.

Conversations with Ventura County FSP staff and clinicians have revealed that outcome goals and metrics are not regularly reassessed or informed by community input, nor are they well-connected to actual services received and provided by FSP programs. There is not a shared, clear understanding of FSP service guidelines among providers and county department staff—interpretation and implementation of these guidelines varies widely. Further, there is not a standard documented model of care designed for each FSP age grouping (Youth, TAY, Adult, Older Adult). FSP has a different meaning and objectives within each group, but is not formally documented. As age categories are further documented, identifying the idiosyncratic challenges particular to each target group due to the needs being very different.

Staff and clinicians have also indicated that data is collected for state mandated compliance and does not inform decision-making or service quality improvements. In addition, data is collected within one system, but outcomes are designed to be measured with cross-agency data collection systems (such as health care, criminal justice, etc.) meaning many counties are reliant on self-reported progress toward outcomes rather than verified sources. Providers and peer agencies do not have a forum to meet regularly and share learnings and best practices or discuss opportunities. Standards for referral, enrollment, and graduation are inconsistent or outdated. Finally, there is a need for more clarity in the understanding of FSP funding allowances. The “whatever it takes” category is especially open to interpretation and there’s no standard across counties to compare approved expenditures or to know what resources are available through FSP funds

Response to Local Need

Through this Innovation proposal, Ventura County seeks to participate in the statewide initiative to increase counties’ collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan will allow Ventura County Behavioral Health to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable the department to:

1. Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Explore how appropriate goals and metrics may vary based on population.
3. Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices.
4. Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning.
5. Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified).

In addition, this project will provide Ventura County Behavioral Health the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community.

Local Community Planning Process

The community planning process helps Ventura County determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. The community planning process includes participation from the Board of Supervisors, Behavioral Health Advisory Board, providers, and community members. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The project was shared in the following Behavioral Health Advisory Board subcommittee meetings:

- Adult Committee on Thursday, November 7, 2019
- Executive Meeting on Tuesday, November 12, 2019
- Prevention Committee on Tuesday, November 12, 2019
- Youth & Family Committee on Wednesday, November 13, 2019
- TAY Committee on Thursday, November 21, 2019
- General Meeting on Monday, November 18, 2019

This project was shared as a part of the 3 year-plan update in the section of proposed use of Innovation funds. A more detailed draft plan proposal was posted for a 30-day public comment period beginning on December 16, 2019. The Behavioral Health Advisory Board held a public hearing on the proposed plan on January 27, 2020. The plan will be revised based on any feedback received, after which it is scheduled to go before the Ventura County Board of Supervisors for review and final approval on March 10, 2020.

County Budget Narrative

Ventura County will contribute $979,634 using MHSA Innovation funds over the 4.5-year project period to support this statewide project. As of this time, Ventura County intends to use funding subject to reversion at the end of FY 19-20 for the entirety of this contribution.

As detailed below, Ventura County will pool most of this funding with other counties to support consultant and contracting costs, with a small portion of Ventura County's funding also set aside for county staff travel and administrative costs:

- *County Travel and Administrative Costs:* Ventura County anticipates travel costs up to $13,000 over the 4 years, or $3,000 per year, which may vary based on the number of staff traveling and the number of in-person convening's. Based on current rates for administrative costs, Ventura County will allocate $296,801 for 4 years of personnel costs. The following positions have been allocated at a few hours annually over the next few years in order to achieve the project goals of system change.
    - Senior Project Manager
    - Program Administrator
    - Quality Assurance Administrator

- Electronic Health Record System Coordinator
- Behavioral Health Clinician

- *Shared Project Costs:* The remaining amount, $593,412 will support project management and technical assistance (e.g., Third Sector's technical assistance in project implementation), fiscal intermediary costs, and evaluation.

County Budget Request by Fiscal Year

The table below depicts Ventura County's year-over-year contribution to the Multi-County FSP Innovation Project.

County Budget Request and Expenditures by Fiscal Year and Budget Category

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$21,531	$65,797	$67,771	$44,909	$46,256	$246,264
2	Direct Costs						
3	Indirect Costs						
4	Total Personnel Costs	$21,531	$65,797	$67,771	$44,909	$46,256	$246,264
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$1,000	$3,000	$3,000	$3,000	$3,000	$13,000
6	Indirect Costs	$9,785	$29,293	$29,293	$29,293	$29,294	$126,958
7	Total Operating Costs	$10,785	$32,293	$32,293	$32,293	$32,294	$139,958
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**

8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$58,353	$326,706	$113,435	$0	$0	$498,494
11b	Direct Costs (CalMHSA)	$5,850	$33,338	$12,188	$938	$938	$53,250
11c	Direct Costs (Evaluator)	$0	$10,417	$10,417	$10,417	$10,417	$41,668
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$64,203	$370,461	$136,040	$11,355	$11,355	$593,412
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
EXPENDITURE TOTALS							
Personnel		$21,531	$65,797	$67,771	$44,909	$46,256	$246,264
Direct Costs		$65,203	$373,461	$139,040	$14,355	$14,355	$606,412
Indirect Costs		$9,785	$29,293	$29,293	$29,293	$29,294	$126,958

Total Individual County Innovation Budget*	$96,519	$468,551	$236,104	$88,557	$89,905	$979,634
CONTRIBUTION TOTALS						
Individual County Contribution	$64,203	$370,461	$136,040	$11,355	$11,355	$593,412
Additional Funding for County-Specific Project Costs	$32,316	$98,090	$100,064	$77,202	$78,550	$386,222
Total County Funding Contribution	$96,519	$468,551	$236,104	$88,557	$89,905	$979,634

Appendix: Fresno County Budget Tables

As mentioned above, Fresno County submitted an Innovation Project proposal to the MHSOAC in June 2019, detailing Fresno's participation in this project. This plan has been approved by the commission and thus. Additional appendix detail on local need is not included here as this information is more comprehensively outlined in Fresno's Innovation Plan proposal.

A summary of Fresno's approved budget follows below. Note that the approved Fresno County budget includes costs for Third Sector, CalMHSA and the third-party evaluation in a single total under "Other Project Expenditures"), approximately $840,000 total over the 4.5 years.

COUNTY BUDGET REQUEST BY YEAR						
	FY 19/20	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
Fresno County Funding Contribution	$237,500	$237,500	$237,500	$237,500	$0	$950,000

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$11,375	$11,944	$12,541	$13,168	$0	$49,028
2	Direct Costs	$4,857	$5,100	$5,355	$5,623	$0	$20,935
3	Indirect Costs	$0	$0	$0	$0	$0	$0
4	Total Personnel Costs	$16,232	$17,044	$17,896	$18,791	$0	$69,963
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$10,000	$10,000	$10,000	$10,000	$0	$40,000
6	Indirect Costs	$0	$0	$0	$0	$0	$0

7	Total Operating Costs	$10,000	$10,000	$10,000	$10,000	$0	$40,000
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11	Direct Costs	$0	$0	$0	$0	$0	$0
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$0	$0	$0	$0	$0	$0
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$221,685	$210,456	$209,604	$198,292	$0	$840,037
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$221,685	$210,456	$209,604	$198,292	$0	$840,037
BUDGET TOTALS							
Personnel		$11,375	$11,944	$12,541	$13,168	$0	$49,028
Direct Costs		$14,857	$15,100	$15,355	$15,623	$0	$60,935
Indirect Costs		$221,685	$210,456	$209,604	$198,292	$0	$840,037

Total Individual County Innovation Budget*	$247,917	$237,500	$237,500	$227,083	$0	$950,000

Appendix: San Mateo County Budget Tables

As noted above, San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use unspent MHSA CSS funds to participate in the goals and activities of this project, alongside other counties. These are one-time funds that have been designated and approved through a local Community Program Planning (CPP) process to meet a similar purpose and set of objectives as the Multi-County FSP Innovation Project.

Local Community Planning Process

On October 2, 2019, the San Mateo County MHSA Steering Committee reviewed a "Plan to Spend" one-time available funds, developed from input received through the following:

- The previous MHSA Three-Year Plan CPP process - 32 community input sessions
- Behavioral Health and Recovery Services budget planning - 3 stakeholder meetings
- Additional targeted input sessions to further involve community-based agencies, peers, clients and family members in the development of the Plan to Spend including:
    - MHSARC Older Adult Committee – June 5, 2019
    - MHSARC Adult Committee – June 19, 2019
    - MHSARC Youth Committee – June 19, 2019
    - Contractor's Association – June 20, 2019
    - Office of Consumer and Family Affairs/Lived Experience Workgroup – July 2, 2019
    - Peer Recovery Collaborative – August 26, 2019

The Plan to Spend included $500,000 to better align San Mateo'sSan Mateo's FSP programming with BHRS goals/values and improve data collection and reporting. The proposed Multi-County FSP Innovation Project was brought forward as the means to accomplish this goal. San Mateo's local mental health board, the Mental Health and Substance Abuse and Recovery Commission (MHSARC), reviewed the Plan to Spend and on November 6, 2019 held a public hearing, reviewed comments received and voted to close the 30-day public comment period. The Plan to Spend was subsequently approved by the San Mateo County Board of Supervisors on April 7, 2020. The Plan to Spend also included $250,000 for any ongoing needs related to FSP program improvements. San Mateo has brought forward the proposed Multi-County FSP Innovation Project as the means to accomplish this longer-term goal. The update to the Plan to Spend will be included in the current San Mateo County FY 2020-2023 Three-Year Plan and Annual Update, which will be brought to the San Mateo County Board of Supervisors for approval, likely in August 2020. San Mateo is not submitting a proposal to use INN funds. Detailed appendix information is thus not included below, though a summary of San Mateo's intended funding amounts and expenditures follows below. Note that, like other counties, these amounts are subject to change and further local input and approval.

COUNTY BUDGET REQUEST BY YEAR						
	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total

San Mateo County Funding Contribution	$500,000	$250,000	$0	$0	$0	$750,000

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$0	$0	$0	$0	$0	$0
2	Direct Costs	$0	$0	$0	$0	$0	$0
3	Indirect Costs	$0	$0	$0	$0	$0	$0
4	Total Personnel Costs	$0	$0	$0	$0	$0	$0
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$0	$0	$0	$0	$0	$0
6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$0	$0	$0	$0	$0	$0
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**

(training, facilitation, evaluation)							
11a	Direct Costs (Third Sector)	$58,353	$326,706	$113,435	$0	$0	$498,494
11b	Direct Costs (CalMHSA)	$5,850	$33,338	$12,188	$938	$938	$53,250
11c	Direct Costs (Evaluator)	$0	$49,564	$49,564	$49,564	$49,564	$198,256
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$64,203	$409,608	$175,187	$50,502	$50,502	$750,000
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS							
Personnel		$0	$0	$0	$0	$0	$0
Direct Costs		$64,203	$409,608	$175,187	$50,502	$50,502	$750,000
Indirect Costs		$0	$0	$0	$0	$0	$0
Total Individual County Budget*		$64,203	$409,608	$175,187	$50,502	$50,502	$750,000

Innovation Plan Appendix B: Cohort 2

Appendix Overview

The following appendix contains specific details on the local context, local community planning process, and budget details for the two counties participating in the Multi-County FSP Innovation Project as Cohort 2:

1. Stanislaus County
2. Lake County

Each county appendix describes the county-specific need for this Multi-County FSP Innovation Project. Though there can be slight differences among participating counties' needs in terms of either the prioritization or the specifics, the response to this local need will be similar among counties through the execution of the Innovation Plan. Each county appendix also outlines a county-specific budget narrative and budget request by fiscal year, with detail on specific budget categories.

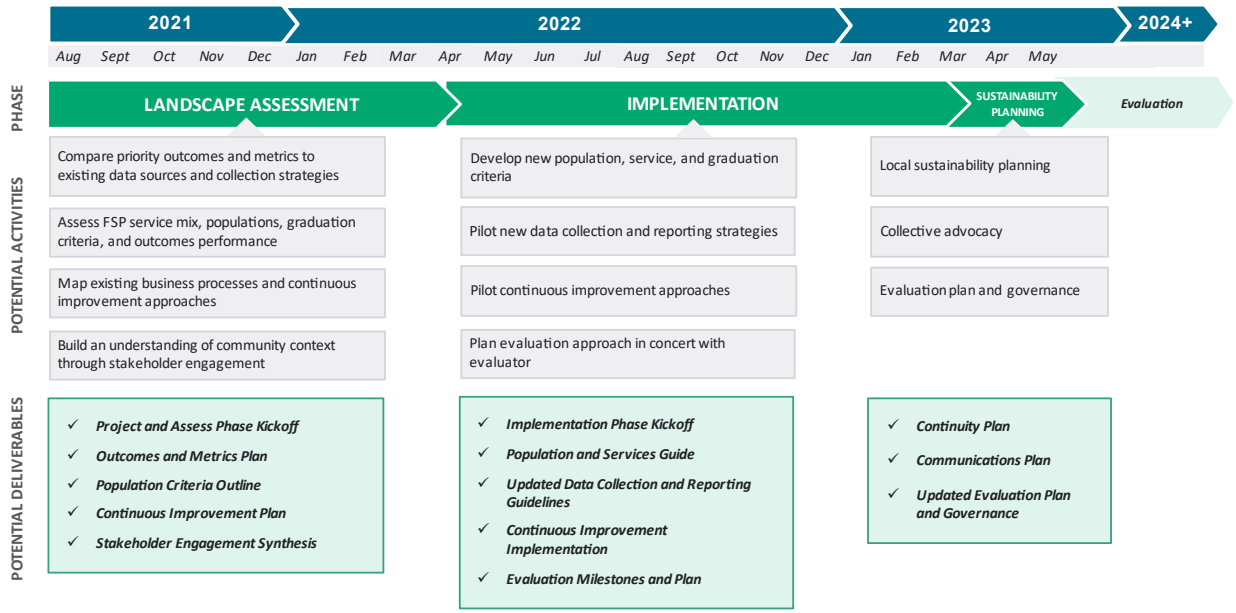
Work Plan and Timeline

Cohort 2 counties will join the Multi-County FSP Innovation Project in August 2021 and follow a similar work plan and timeline as the original six counties over the course of the subsequent 4.5 years. See ***Figure 3*** below for an illustrative Implementation TA work plan and timeline by phase.

While some adjustments in process and structure may occur to fit the unique needs of the next cohort, the goals of the project will remain consistent:

- Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation
- Explore how appropriate goals and metrics may vary based on population (e.g., age, acuity, etc.)
- Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices
- Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning
- Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified)

Figure 3: Cohort 2 Illustrative Implementation TA Work Plan



Benefits of Project Expansion

The addition of the Cohort 2 counties to the Multi-County FSP Innovation Project will grow the impact of the project across the state. The current six counties are developing a more consistent, data-driven approach to FSP that includes standardizing population definitions, process measures, and outcomes, as well as creating recommendations to improve the Data Collection & Reporting System (DCR). Cohort 2 counties will not only be able to adopt the work done to- date but will also be able to build upon the work with a fresh perspective. Examples may include:

- Adding child population definitions, process measures, and outcomes to the existing list of adult definitions and measures developed by Cohort 1
- Furthering the efforts to update the DCR by continuing to work with counties across the state and DHCS on potential improvements.

Cohort 2 will benefit the state by both expanding on current initiatives and by increasing the resources available to other counties statewide by adding more 'tools to the toolkit.'

Another benefit of growing the Innovation Project is the expansion of knowledge sharing across counties. In addition to joining the cohort-wide work done to date, Cohort 2 counties will also be focusing on several county-specific implementation initiatives to create lasting improvements within their individual FSP programs. By joining the existing project, new counties will be able to leverage best practices and lessons learned from the six counties that have already begun local implementation. For example, if Stanislaus County determines they need to standardize their local graduation criteria across programs, they will benefit from the five other counties that have already gone through this process. In turn, Cohort 1 counties will also be able to apply any new learnings from Cohort 2 counties through their continuous improvement structures.

All of these learnings will also be shared across the state through the Outcomes-Driven FSP Learning Community, a forum for County MHSA and FSP staff, FSP providers, FSP clients, and other community stakeholders to help increase statewide consensus on core FSP components and develop shared recommendations for state-level changes to FSP data requirements and guidelines. Third Sector is supporting the first several Learning Communities with the intention for the long-term forum to be largely county-driven and county-led. The addition of Cohort 2 counties means there will be more individuals available to coordinate, plan, and facilitate future Learning Communities in order to continue engagement statewide.

Finally, Cohort 2 counties will be added to the existing project evaluation, creating a broader understanding of the impact of direct technical assistance, highlighting additional learnings and benefits of a multi-county collaborative, and driving consistent data collection and analyses across all participating counties. While the current six counties are incorporating equitable data practices and working to disaggregate data by race, Cohort 2 counties will be able to further these efforts. For example:

- Stanislaus County will be incorporating a Human Centered Design (HCD) approach into their stakeholder engagement in order to ensure all initiatives are co-developed by the community.
- Lake County, with a population of 65,000, will be the second frontier county to join the collaborative, further elevating the voice and unique needs of rural county populations and systems of care.

Ultimately, the addition of Cohort 2 counties will bring California one step closer to having consistent data to compare FSP programs and outcomes in a meaningful and equitable way and share best practices statewide through regular collaborative forums.

Budget Narrative

The total proposed budget supporting Cohort 2 counties in pursuing this Innovation Project, which includes Stanislaus County and Lake County, is approximately $2.5M over 4.5 years. This includes project expenditures for four different primary purposes: Third Sector implementation TA ($1.43M), fiscal and contract management through CalMHSA ($151K), third-party evaluation ($250K), as well as additional expenditures for county-specific needs (“County-Specific Costs”) ($680K).

All costs will be funded using county MHSA Innovation funds. If multiple counties join, each county will contribute varying levels of funding towards a collective pool of resources that will support the project expenditures (excluding County-Specific Costs, which counties will manage and administer directly). This pooled funding approach will streamline counties’ funding contributions and drawdowns, reduce individual project overhead, and increase coordination across counties in the use of these funds. The Appendix includes additional detail on each county’s specific contributions and planned expenditures.

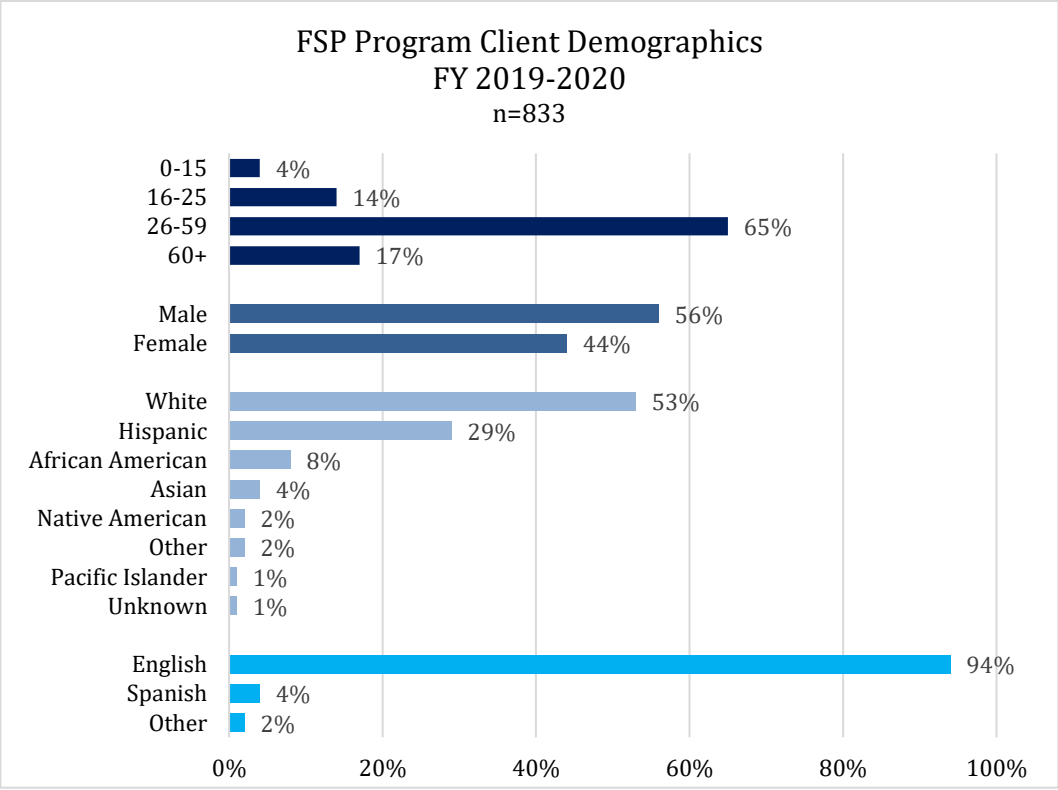
Appendix: Stanislaus County

County Contact and Specific Dates

- Martha Cisneros Campos, mcisneros@stanbhrs.org, 209-525-5324
  Kirsten Jasek-Rysdahl, KJasek-Rysdahl@stanbhrs.org, 209-525-6085
- Date Proposal posted for 30-day Public Review: April 21, 2021
- Date of Local MH Board hearing: May 27, 2021
- Date of BOS approval or calendared date to appear before BOS: June 15, 2021

Description of the Local Need

Stanislaus County Behavioral Health and Recovery Services (BHRS) currently has eight Full Service Partnership (FSP) programs, and during FY 2019-2020 these programs served a total of 833 clients. The client demographics illustrate the populations that are receiving the majority of FSP program services, but it is not clear if this reflects the current needs of Stanislaus County.



Although these clients represent some of the most underserved or unserved community members, it has been over a decade since BHRS implemented FSP programs by utilizing a comprehensive and thorough approach to explore the demographic and individual needs of Stanislaus County's FSP population. Since we are dedicated to continuously evaluate what is working well and what could be improved in our FSP programs, BHRS has recently engaged the community to update and further

understand and address the unique challenges and needs of our FSP clients. We plan to leverage this engagement and apply a human-centered design (HCD) approach through this Innovation Project. In addition, BHRS recognizes the need to share outcomes with our stakeholders to both inform and elicit feedback from the community. Stakeholders have expressed strong interest in improving FSP program data and better understand program outcomes.

BHRS has identified the need and desire to use and share meaningful data in a clear and engaging way to better understand if our FSP programs are truly resulting in positive recovery outcomes for the clients served. This also includes reviewing ways to improve where we are less successful, e.g., exploring ways that BHRS can be more responsive to individuals' needs, and to better coordinate with other community partners. BHRS overarching goals for this project are reflected below:

- More clearly identify priority outcomes for FSP clients
- Develop effective data collection and tracking mechanisms to increase the accuracy and meaning of FSP data for transforming into performance measures and outcomes
- Create an FSP framework and practices that foster continuous improvement of outcomes for FSP clients
- Develop sustainable ways to continuously evaluate how BHRS FSP programs are effectively meeting the community needs

In recent years, BHRS staff have explored ways to improve data collection, analysis, presentation, and use of data to be more outcome oriented and data-driven, but there are multiple issues and challenges that affect our ability to meet our overarching goals:

- Consistent and accurate data collection by staff is challenging.
    - Staff are focused on quality care and it is often difficult to elicit buy-in for the importance of entering and utilizing client data regularly when using the DCR and other databases is time consuming.
    - Data collection tools can be confusing or frustrating for staff.
- Extracting, analyzing, presenting, and interpreting/creating meaning from data requires skilled staff and time.
- Utilizing data consistently for improvement requires monitoring and resources committed to that practice.
- Stakeholders have multiple perspectives about what data and outcomes are meaningful, and how to use this information.
- Data-driven decisions regarding program design/revisions can be difficult to implement and sustain.

Since BHRS internal resources are limited as described above, this Innovation Project will provide the support and shared learning necessary to fulfill the goals outlined above.

Description of the Response to the Local Need

The proposed Innovation Project will address Stanislaus County BHRS' FSP program challenges and needs through a thorough and inclusive approach. The project will support BHRS in implementing

improvements in how we design, provide, and continuously improve FSP programs in the following ways:

- Create shared understanding of current FSP programs – who the programs are serving, how they are serving them, and what data is being collected to yield outcome measurement
- Include stakeholders in the identification of FSP program strengths and areas of improvement
- Identify problem statements that can be used to create FSP programs that are data and outcome oriented
- Develop and support data collection, analysis, and presentation processes that allow BHRS to identify disparities through demographics and outcomes data, as well as ensure individual clients are connected to appropriate and customized services to increase positive outcomes
- Identify and define FSP program outcome goals, and develop meaningful performance measures to track progress towards goals; concurrently develop sustainable processes for using the data for continuous tracking and improvement
- Clarify, streamline, and improve design and practices within FSP programs to better serve our County's FSP population and subpopulations
- Leverage other counties' processes, learning, and best practices while participating in the Multi-County FSP Innovation Project

Ultimately, this project will help BHRS meet the overarching goals of identifying priority outcomes for FSP clients, developing effective data collection techniques and ongoing measurement, creating an effective FSP framework to improve FSP client outcomes, and developing a structure for continuous evaluation of how well BHRS FSP programs are meeting community needs.

Cultural & Linguistic Competency

Based on the Department of Finance January 2020 population estimates, Stanislaus County has 557,709 residents, of which 45.6% reported Hispanic/Latino; 42.6% reported White; 5.3% reported Asian; 2.6% reported Black; 2.5% reported Two or more races (not Hispanic/Latino); .7% Native Hawaiian or Pacific Islander; .5% reported American Indian and Alaska Native; and .2% reported Other Race (not Hispanic/Latino).

Although diverse, Stanislaus County currently has one threshold language of Spanish. BHRS county staff consist of approximately 25% Spanish speaking staff. In addition, we have staff that speak other languages such as; Cambodian, Assyrian, Hindi, and many other languages. When programs are unable to have a staff person assist in translation, programs utilize our contracted translators (including American Sign Language) or connect with Language Line.

BHRS is committed to strategies that embrace diversity and to provide welcoming behavioral health and compassionate recovery services that are effective, equitable, and responsive to individuals' cultural health beliefs and practices. To ensure we continue to improve the quality of services and eliminate inequities and barriers to care for marginalized cultural and ethnic communities, BHRS supports the Cultural Competence, Equity, and Social Justice Committee (CCESJC). The committee consists of program providers, consumers, family members, and communities representing all cultures and meets monthly to discuss cultural and linguistic needs of our county. Our Cultural Competence and Ethnic Services Manager chairs the committee and ensures the county behavioral health systems are culturally and linguistically competent and responsive in the delivery of behavioral health services. This innovation

project will support the cultural and linguistic needs of the county through a better understanding of the client needs.

Description of the Local Community Planning Process

Stanislaus County Behavioral Health and Recovery Services (BHRS) had been actively engaging in the Community Planning Process specifically with the intent to inform engaged stakeholders on updates facing MHSA, with the focus of strengthening stakeholder engagement. Traditionally stakeholder meetings were convened twice a year, in some years quarterly. However, with the onset of the Covid-19 crisis that began in March of 2020 and policy effects on MHSA, BHRS identified the opportunity to create a more robust stakeholder process. In this effort stakeholders were informed formally of MHSA regulations and their specific role as it relates to the community planning process for the three-year plan and annual update.

Formal Representative Stakeholder Steering Committee (RSSC) meetings for MHSA were held on June 12th, June 26th, September 18th, and December 11th of 2020. Each meeting averaged 62-80 participants; the information session had 44 attendees. The meeting held on December 11, 2020 was also offered in person at the new Granger Community Center to gain additional participation from peers and consumers. During the December 11th meeting RSSC members were informed of the reversion issue facing BHRS; related to unspent innovation funds from previous fiscal periods. Stanislaus and other counties facing this issue, were encouraged by the MHSOAC to explore alignment with innovation projects already approved. BHRS quickly observed that two multicounty collaborative innovation projects provided by the MHSOAC aligned very well with insights from stakeholder input on the BHRS system as whole and one aligned well with BHRS efforts to create a more robust stakeholder process for future innovations.

To explore this further and to ensure stakeholder support on these innovation projects, BHRS conducted an information session that detailed each project proposed as well as allowed time for discussion and questions surrounding these projects. The information session for proposed innovations was a dedicated meeting for proposed innovations on December 29th. Following the December 29th innovation information session stakeholders were invited to the RSSC meeting on January 15, 2021 to formally measure the level of support to move forward and pursue the proposed innovation projects. After engaging in small group discussion and large group feedback discussion, RSSC members were surveyed utilizing the gradients of agreement scale; a scale utilized to measure the level of agreement and support towards a proposal. BHRS provided a one through five scale, with one being non acceptance of the proposed project and five being complete and full acceptance. RSSC members identified fours and fives as their measurement during this meeting. The meeting concluded with agreement to move forward with all three proposed innovations.

Proposed projects will go formally to the Stanislaus County Board of Supervisors (BOS) on June 15, 2021. Following formal approval by the BOS the projects will go through the review period with the MHSOAC as well be posted for the 30-Day local review period for the public.

TOTAL BUDGET REQUEST BY FISCAL YEAR:

Total budget by fiscal year for the county collaborative portion of the costs.

	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	TOTAL
Total County Contribution to Collaborative	412,729	838,017	330,999	175,401		1,757,146

BUDGET NARRATIVE FOR COUNTY SPECIFIC NEEDS:

Personnel

The total personnel cost for the county portion is $648,035 over four years. This includes $386,574 for salaries and $261,461 for fringe benefits.

Personnel will include a 0.5 FTE Software Developer/Analyst III and a 0.5 FTE Staff Services Coordinator for four years.

These two positions will provide the following support to contribute to the success of this Innovation Project.

Staff Services Coordinator will:

- Oversee and act as liaison to the Innovation Project contractors
- Coordinate and facilitate meetings and discussions amongst Innovation Project contractors, partners, and other stakeholders
- Coordinate internal staff and project partners to ensure the necessary assignments are completed to meet project requirements, timelines, and quality expectations
- Develop and monitor project timelines; provide updates/status of projects to stakeholders as appropriate
- Oversee, coordinate, and provide technical assistance for the data collection, analysis and reporting of the performance measures for this Innovation Project
- Provide training and technical assistance related to project data and results to staff and stakeholders

Software Developer/Analyst III will:

- Help identify the appropriate county-level data and data transfer methods
- Extract county-level data from the electronic health record, DCR, and other program databases and sources; de-identify data before transferring to contracted staff
- Identify problems and possible solutions in the county-level data (e.g., issues with available data or methods)
- Participate in all relevant meetings regarding data for this Innovation Project

The personnel costs include a 3% annual increase to include cost-of-living salary increases and the associated retirement, and FICA increases based on the increased salaries as well as increases for health care costs.

Operating Costs

The ongoing operating costs total $24,560 over four years. This includes cell phones, office supplies, copier costs, computer licenses, MiFi service for laptops, utilities, alarm and security costs, zoom subscriptions, telephone and data processing services, and janitorial costs.

Nonrecurring Costs

Nonrecurring costs total $10,900 for equipment for the set-up of the office for the two staff members. This includes, desks, chairs, computers, laptops, and software.

Consultant Costs/Contracts

The budget includes $1,073,651 for contracted services over three years. This includes $810,000 for Third Sector, $88,651 for CalMHSA, and $175,000 for RAND as the Evaluator.

The total budget over four years is $1,757,146.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY SPECIFIC NEEDS

EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Salaries	154,898	159,545	164,331	169,261		648,035
2.	Direct Costs						
3.	Indirect Costs						
4.	Total Personnel Costs	154,898	159,545	164,331	169,261		648,035
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5.	Direct Costs	6,140	6,140	6,140	6,140		24,560
6.	Indirect Costs						
7.	Total Operating Costs	6,140	6,140	6,140	6,140		24,560
NONRECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
8	Desk, Chair, Computer, Laptop	9,900					9,900
9.	Software	1,000					1,000
10.	Total Non-recurring Costs	10,900					10,900

CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	TOTAL
11a.	Direct Costs (Third Sector)	210,909	559,091	40,000			810,000
11b.	Direct Costs (CalMHSA)	19,882	55,514	13,255			88,651
11c.	Direct Costs (RAND)	10,000	57,727	107,273			175,000
12.	Indirect Costs						
13.	Total Consultant Costs	240,791	672,332	160,528			1,073,651
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS:							
Personnel (line 1)		154,898	159,545	164,331	169,261	-	648,035
Direct Costs (add lines 2, 5 and 11 from above)		246,931	678,472	166,668	6,140	-	1,098,211
Indirect Costs (add lines 3, 6 and 12 from above)							
Non-Recurring costs (line 10)		10,900					10,900
Other expenditures (line 16)							
TOTAL INNOVATION BUDGET		412,729	838,017	330,999	175,401		**1,757,146**

BUDGET NARRATIVE FOR TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR:

Funding for the project will come from MHSA Innovation funds.

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY):

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for <u>ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	402,729	780,290	223,726	175,401		1,582,146

2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Administration**	402,729	780,290	223,726	175,401		1,582,146
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	10,000	57,727	107,273			175,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Evaluation**	10,000	57,727	107,273			175,000
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total for funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	412,729	838,017	330,999	175,401		1,757,146
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other Funding						
6.	**Total Proposed Expenditures**	**412,729**	**838,017**	**330,999**	**175,401**		**1,757,146**

Appendix: Lake County

County Contact and Specific Dates

The primary contact for Lake County is:

Scott Abbott
Email: scott.abbott@lakecountyca.gov
Tel: 707-274-9101

Lake County Behavioral Health Services' (LCBHS) local review dates are listed in the table below. More detail on Lake's stakeholder engagement process can be found in the "Local Community Planning Process" section.

Local Review Process	Date
Innovation Plan posted for 30-day Public Review *No public comment was received during this time*	June 22, 2021
Local Mental Health Board Hearing approval	July 22, 2021
Board of Supervisors (BOS), calendared date to appear before BOS	September 14, 2021

Description of Local Need

Lake County operates four Full Service Partnership (FSP) programs: Children's, Transitional Age Youth, Adult, and Older Adult programs that combine to serve approximately 120 individuals annually. Program eligibility is determined by diagnosis and risk factors pursuant to the Mental Health Service Act (MHSA) regulations for FSP criteria. Each Partner is assigned a clinician and case manager that work in the appropriate program as determined by the Partner's age receiving treatment services such as case management and linkages, rehabilitation, therapy, and ongoing assessment and plan development. FSPs may also receive psychiatric services and/or housing support services upon referral by the primary service provider. Many Partners also receive services through the peer support centers around the county.

Due to the specificity and flexibility of the FSP program, the county has encountered difficulty developing consistent FSP service guidelines, evaluating outcomes, and disseminating best practices. Lake County utilizes the Data Collection Reporting (DCR) database developed by the State to track outcomes, however, due to a variety of systematic and technical challenges the DCR has limited utility for informing treatment decisions or promoting quality improvements.

LCBHS management and community stakeholders have consistently identified the need for clear, consistent and reliable data and outcomes to assist programs in identifying goals, measuring success and pinpointing areas that may need improvement. Though outcome measurements are desired, up until recently LCBHS has rarely received program feedback based on quantitative outcome data and has relied on qualitative data and reports obtained from the Electronic Health Record. Conversations with

Lake County FSP staff and clinicians have revealed that outcome goals and metrics are not regularly reassessed or informed by community input, nor are they well-connected to actual services received and provided by FSP programs.

LCBHS is seeking to establish, identify, and define clear guidelines ("guardrails") for each step in a client's journey through FSP to support decision making and provide clients with a clear vision for their experience in the program, while retaining the flexible "whatever it takes" FSP philosophy. Historically, ambiguity around these steps has resulted in confusion and unexpected challenges for clinicians and clients, and made it difficult to manage the program with a data-driven approach. For example, without clear standards for engagement, LCBHS has struggled to set targets for regular contact with clients that are tailored to the client's needs and stage of recovery. If these targets were in place and informed by relevant outcomes data on an ongoing basis, LCBHS would be able to more effectively allocate clinician and case worker time to meet clients "where they are" while focusing resources where they are needed most. Similarly, clear standards for graduation from FSP would give clients a long-term goal to work towards, while facilitating more consistent, tailored services as clients progress in their recovery.

Response to Local Need

Through this Innovation proposal, Lake County Behavioral Health Services seeks to participate in the statewide initiative to increase counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan will allow Lake County Behavioral Health Services to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable the department to:

1. Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Explore how appropriate goals and metrics may vary based on population.
3. Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices.
4. Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning.
5. Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified).

In addition, this project will provide Lake County Behavioral Health Services the opportunity to share and exchange knowledge with other counties participating in this project and through the statewide learning community.

Local Community Planning Process

The community planning process helps Lake County determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. The community planning process includes participation from the Board of Supervisors, Behavioral Health Advisory Board, providers, community-based organizations, consumers, community members and partners. Since the community

planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The project was shared in a large quarterly MHSA stakeholder meeting on April 15, 2021 with over 37 virtual participants. After the presentation of the local needs assessment and a review of this proposed use of innovation funds, stakeholders acknowledged the project as an appropriate use of funding. The project was also shared in the MHSA Fiscal Year 2020 – 21 Annual Update and at the quarterly Innovations Steering Committee on June 17, 2021.

A draft plan was publicly posted for a 30-day comment period beginning on June 22, 2021 and no public comments were received. In addition, the plan was presented at the Lake County Mental Health Board Hearing on July 22, 2021 and approved. The plan is scheduled to go before the Lake County Board of Supervisors for review and final approval on September 14, 2021 (following the MHSOAC's review process).

County Budget Narrative

Lake County will contribute up to $765,000 over the 4.5-year project period to support this statewide project. As detailed below, Lake County will pool most of this funding with other counties to support consultant and contracting costs, with a small portion of Lake County's funding also set aside for county staff travel and administrative costs:

- *County Travel and Administrative Costs*: Lake County anticipates travel costs up to $7,450 over the 4.5 years, which may vary annually based on the number of staff traveling and the number of in-person convenings.

- *Shared Project Costs*: The remaining amount, $757,500 will support project management and technical assistance (e.g., Third Sector's technical assistance in project implementation), fiscal intermediary costs, and evaluation.

Total Budget Request by Fiscal Year

The table below depicts Lake County's year-over-year contribution to the Innovation Project.

Table 1

	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	Total
Individual County Contribution to the Collaborative*	$339,390	$339,390	$28,740	$28,740	$28,740	$765,000

Budget by Fiscal Year and Specific Budget Category

Table 2

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**Total**
1.	Salaries	$0	$0	$0	$0	$0	$0
2.	Direct Costs	$0	$0	$0	$0	$0	$0
3.	Indirect Costs	$0	$0	$0	$0	$0	$0
4.	Total Personnel Costs	$0	$0	$0	$0	$0	$0
Operating Costs (travel, hotel)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**Total**
5.	Direct Costs	$1,490	$1,490	$1,490	$1,490	$1,490	$7,450
6.	Indirect Costs	$0	$0	$0	$0	$0	$0
7.	Total Operating Costs	$1,490	$1,490	$1,490	$1,490	$1,490	$7,450
Non-Recurring Costs (technology, equipment)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**Total**
8.	Direct Costs	$0	$0	$0	$0	$0	$0
9.	Indirect Costs	$0	$0	$0	$0	$0	$0
10.	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**Total**
11a.	Direct Costs (Third Sector)	$310,000	$310,000	$0	$0	$0	$620,000

11b.	Direct Costs (CalMHSA)	$27,900	$27,900	$2,250	$2,250	$2,250	$62,550
11c.	Direct Costs (Evaluator)	$0	$0	$25,000	$25,000	$25,000	$75,000
12.	Indirect Costs	$0	$0	$0	$0	$0	$0
13.	Total Consultant Costs	$337,900	$337,900	$27,250	$27,250	$27,250	$757,550
Other Expenditures (explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**Total**
14.	Program/Project Cost	$0	$0	$0	$0	$0	$0
15.		$0	$0	$0	$0	$0	$0
16.	Total Other Expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS							
Personnel		$0	$0	$0	$0	$0	$0
Direct Costs		$339,390	$339,390	$28,740	$28,740	$28,740	$765,000
Indirect Costs		$0	$0	$0	$0	$0	$0
Total Individual County Innovation Budget		$339,390	$339,390	$28,740	$28,740	$28,740	$765,000

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS—Monterey County

Innovation (INN) Project Name:	**Residential Care Facility Incubator**
Total INN Funding Requested:	**$792,130**
Duration of INN Project:	**Two years (Phase I)**
MHSOAC consideration of INN Project:	**Delegated Authority**

Review History:

Approved by the County Board of Supervisors:	June 30, 2020
Mental Health Board Hearing:	May 28, 2020
Public Comment Period:	April 23, 2020 through May 22, 2020
County submitted INN Project:	August 23, 2021
Date Project Shared with Stakeholders:	August 26, 2021

Project Introduction:

Monterey County requests authorization for the one-time time use of up to $792,130 of Innovation funding to complete phase one of a two-phased Innovation project which **seeks to increase the availability of culturally competent housing for individuals living with serious mental illness.** To accomplish this goal, Monterey County will work with consultants, including peer providers to identify and develop the training and supports needed to equip motivated existing and new property owners to operate culturally and linguistically responsive housing facilities.

What is the Problem (Pages 5-6)

This project identifies housing insecurity as a serious problem to be addressed in order to support individuals living with serious mental illness to establish a path towards recovery and stability.

Monterey County presents data from local reports, statewide and national studies that identify inadequate housing as a contributor to many individuals experiencing a return to crisis following periods of stability or upon release from higher levels of care. Locally, Monterey County has experienced a decrease in the number of board and care homes operating. The decrease in available residential facilities has exacerbated the lack of affordable housing with the needed supports and services for individuals in need.

Monterey County identifies many barriers impacting property owners and preventing them from choosing to operate residential facilities. These barriers include a lack of support in the community and from oversight entities, financial concerns, and difficulty to maintain adequate staffing. The County hypothesizes that property owners will be more inclined to open or continue operating a residential facility for individuals with serious mental illness, if the owners have adequate support, training, and technical assistance all through the lens of embracing cultural and linguistic identities in both the owner operators and in the clients themselves.

How this Innovation project addresses this problem (pages 6-7)
To address the housing insecurity experienced by many individuals living with serious mental illness, Monterey County is proposing a two-phased Innovation project that will seek out existing, motivated residential care facility operators interested in providing more culturally and linguistically responsive services, as well as engage new property owners interested in establishing new culturally and linguistically responsive residential care facilities.

Phase I of the project is focused on research and planning. This process will involve hiring consultants, including peer providers, with expertise in residential care facilities, cultural competency, and small business operations, to identify and develop training and supports needed to equip property owners with the tools to be successful in providing culturally and linguistically responsive housing options.

Phase I will also include in-depth research to better understand the housing challenges facing individuals living with serious mental illness within specific cultural groups, as well as the challenges facing residential care facility operators. The County has included a review of related projects in their proposal (page 6) and has been encouraged to incorporate lessons learned from other counties into the development of phase II training and supports. Results from the phase I research will be used to develop the infrastructure and materials to support participating property owners in operating successful culturally and linguistically responsive residential care facilities.

Once phase I is successfully completed, Monterey County will return to the Commission to request approval for phase II which will focus on implementation where consultants, including peer providers, will provide training and technical assistance to property owners. Once fully trained and operational, County staff will begin referring clients to the facilities and continue to provide existing supportive services.

Community Planning Process (Pages 10-11)

Local Level
The concept which developed into this innovation plan was created during the Community Program Planning Process for the Mental Health Services Act (MHSA) FY 2021-23 Three-year Program and Expenditure Plan. Monterey County held ten community engagements throughout the county, and a total of 181 community stakeholders participated. Three themes

emerged which helped originate and form this Innovation Plan to incubate culturally and linguistically responsive residential care facilities:

- Deepen and Expand Culturally Responsive, Trauma-informed Staffing, Approaches & Practices
- Expand In-place, Embedded Culturally Responsive Care
- Foster Policy, Systems Change

Following stakeholder input, Monterey County proposed this project plan in their MHSA Three-Year Program and Expenditure Plan, with corresponding public comment period held April 23, 2020 through May 22, 2020 followed by local Mental Health Board hearing on May 28, 2020.

A final phase I plan, incorporating stakeholder input and MHSOAC technical advice, was submitted to Commission staff on August 23, 2021.

Commission Level

The final version of this project was shared with stakeholders on August 26, 2021. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

One comment was received in response to Commission sharing plan with stakeholder contractors, the listserv, and Committees. The comment was shared with the county and is supportive of the proposal:

"Focusing on linguistics and cultural aspects, in the Monterey initiative, is also very important. For me, I think a lot of problems would go away if we had greater cultural awareness and sensitivity. Housing and staffing will always be an uphill battle. I commend them for taking this issue on."

Learning Objectives and Evaluation:

Over the course of the project, Monterey County anticipates serving up to 150 individuals who are living with serious mental illness and are either inadequately housed or experiencing homelessness.

Phase I of this Innovation project aims to incentivize property owners to increase the stock of culturally and linguistically responsive housing options for the SMI population. To achieve this goal and prepare for a successful phase II, the County will seek to answer the following questions:

1. What are the attributes of a culturally and linguistically responsive residential care facility that serves the SMI population; and what are the specific needs for culturally and linguistically responsive residential care facilities in Monterey County?

2. What barriers are preventing residential care facilities from being developed and remaining sustainable?

3. What are the required supports to assist property owners who are already culturally and linguistically integrated in the community, who are interested and can be incentivized to turn their home or property into a residential care facility?

4. What support is needed to ensure these residential care facilities are financially sustainable for property owners?

5. What materials and technical assistance will be required to support implementation in Phase II?

The Budget

Funding Source	Year-1	Year-2	**TOTAL**
Innovation Funds	$ 396,065	$ 396,065	$ 792,130
2 Year Budget	Year-1 (6 mo)	Year-2	**TOTAL**
Consultant costs	$ 171,921	$ 171,921	$ 343,842
Personnel Costs	$ 224,144	$ 224,144	$ 448,288
	$ -	$ -	$ -
TOTAL:	$ 396,065	$ 396,065	**$ 792,130**

The County is requesting authorization to spend up to $792,130 in MHSA Innovation funding for this project over a period of two (2) years to increase the stock of culturally and linguistically responsive housing options for the SMI population.

Consultant costs in the amount of $343,842 (43% of total budget) is allocated for contracts with consultants who are subject matter experts in residential care facility certification and management, cultural and linguistic competency, supportive housing services, marketing, and communications. **Consultants will research and design the phase II implementation through collaboration with County staff and community stakeholders.**

Personnel costs total $448,288 (57% of total budget) and include the following positions:

- 0.125 FTE Management Analyst
    - Innovation coordinator to support project management, procurement, reporting and evaluation
- 0.125 FTE Public Health Epidemiologist I
    - Collaborate with consultant and stakeholders in phase I to develop evaluation in phase II
- 0.125 FTE Behavioral Health Services Manager II
    - Monitor deliverables, provide technical assistance

- 1.25 FTE Behavioral Health Aide
    - Peer specialists to support cultural competence and consumer driven activities

Personnel costs include approximately $210,602 (26% of total budget) allocated to staff time needed to design and complete evaluation of phase 1 and the development of the evaluation for phase II.

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

INN-04: Residential Care Facility Incubator

Innovation Project Brief

Contents

Section 1: General Application Information & Innovation Regulation Requirement Categories

County Name: Monterey

Project Title: Residential Care Facility Incubator

Submission Date: 8/23/2021

Total Amount Requested: $792,130

Duration of Project: 2 years

General Requirement: An Innovative Project must be defined by one of the following general criteria. The proposed project:

☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention

☒ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population

☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system

☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose: An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

☐ Increases access to mental health services to underserved groups

☐ Increases the quality of mental health services, including measured outcomes

☒ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes

☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Checklist of Required Approvals and Public Comment

Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☒ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors. *(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*
☒ Local Mental Health Board approval Approval Date: 5/28/2020
☒ Completed 30 day public comment period Comment Period: 4/23/2020 – 5/22/2020
☒ BOS approval date Approval Date: 6/30/2020 If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: _____ *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: _____TBD_____ ***Note: Date requested above is not guaranteed until MHSOAC staff verifies <u>all requirements</u> have been met.***

Section 2: Project Overview

Primary Problem

Residential care facilities for adults experiencing serious mental illness (SMI) in Monterey County, including Board and Care Homes (B&Cs) and Adult Residential Facilities (ARFs), do not directly associate as being culturally and linguistically responsive to the needs of county residents. In addition, at least three B&Cs in Monterey County have closed in recent years, resulting in a loss of over 50 beds for adults with SMI. Inadequate housing options for people experiencing SMI leads to a "revolving door scenario" where individuals are released from higher levels of care, but then are unable to find suitable residential care or housing. This often leads to another mental health crisis and a return to high-level crisis programs, facilities, hospitals, jails/prisons, or homelessness (CBHPC, 2018). The New Freedom Commission on Mental Health reports that "the lack of affordable housing and accompanying support services often causes people with serious mental illnesses to cycle between jails, institutions, shelters, and the streets" (Judicial Council of California Task Force for Criminal Justice Collaboration on Mental Illness: Final Report (2011, p.305).

Currently, 13 B&Cs in Monterey County offer 169 total beds for adults experiencing SMI. None of these have been intentionally designed to be culturally or linguistically responsive to the needs of county residents. Populations that may benefit from culturally and linguistically responsive residential care facilities include various racial and ethnic groups, gender specific groups, LGBTQ groups, transition age youth 18 -25, older adults, and adults with physical disabilities. Notably, while Latinos make up 78% of Medi-Cal beneficiaries, 59.4% of the overall population and 37% of the homeless population in Monterey County, there are no Latino owned and operated residential care facilities, or ones that provide services that embrace common Latino cultural traditions. This represents a major gap in the current viable housing options for Latino adults experiencing SMI. Monterey County Behavioral Health (MCBH) managers estimate that approximately 100 homeless Adults System of Care (ASOC) consumers and an additional 50 ASOC consumers currently housed in other challenging living situations that may be interested in and would benefit from culturally and linguistically responsive residential care facilities for adults experiencing SMI.

Barriers to opening and maintaining adult residential facilities has led to closures and deterred new facilities from opening. These barriers include financial, lack of community buy-in, and difficulty in maintaining adequate staffing. The inability to sustain ARFs and B&Cs in Monterey County has exacerbated the lack of affordable housing with the necessary supports and services available to those experiencing SMI in our community. Innovative solutions that are less costly to the owners and operators, and provide culturally and linguistically responsive care for consumers, are needed to address the problem.

This project directly responds to the housing gaps for people experiencing SMI in Monterey County by not only aiming to increase the stock of available residential care facilities, but also to support residential care facilities in becoming more culturally and linguistically responsive. It is believed that placing an emphasis on the enhancement of cultural and linguistic responsiveness in residential care facilities will improve the consumer's experience and therefore lead to improved recovery outcomes. Additionally, property owners may be more inclined to open or continue operating a residential care facility for the SMI population if they are encouraged to embrace their cultural and linguistic identity when doing so, in addition to being offered logistical aids and supports via MCBH.

What Has Been Done Elsewhere to Address the Primary Problem? (Research on INN Component)

Counties across California have implemented innovative programs to address the problem of affordable housing for people experiencing SMI. However, few programs directly increase the stock of affordable housing specifically for people experiencing SMI, and none provide culturally and linguistically relevant residential care facilities for this population. Some of the innovative programs Counties have implemented to directly and indirectly address the problem of affordable housing for this population are discussed below.

Orange County's Peer Mentoring program, Placer County's Adult Reintegration Team (ART), Santa Cruz County's Integrated Health and Housing Supports program, Humboldt County's Rapid Rehousing project, and San Diego's Recuperative Treatment Services Program utilize a variety of service delivery methods to assist individuals with SMI in successfully transitioning from inpatient care back into the community. These programs assist consumers in building comprehensive independent living skills as well as linking them to housing services. However, none of these programs directly increase affordable housing for people experiencing SMI.

Other programs include San Joaquin County's Scattered Site Housing and Supported Housing programs, and Santa Clara County's Room Match program, which directly address the problem of linking consumers to housing that provides appropriate levels of support based on the consumers' needs. San Joaquin's Scattered Site Housing provides a graduated approach to permanent housing for people with SMI through housing programs that provide supportive services that are reflective of the varying level of needs required by consumers. In addition, the Supported Housing program is a partnership with the Housing Authority of San Joaquin County to provide long-term supported housing for people experiencing SMI that are returning from or at risk of placement in a higher level of care such as crisis residential or institution. Similarly, Santa Clara County's Room Match program supports the housing needs of consumers experiencing SMI by connecting them to available bedrooms for either short-term or long-term housing in the community. Though currently on hold, this program meets housing needs and incorporates choice for both consumers and renters, and directly addresses the problem of available affordable housing for people experiencing SMI.

Currently, within Monterey County, there is a 'Home Match' program offered and supported through a California-based agency, Front Porch (formerly Covia). This program encourages subletting of rooms within an owned or rented property, however does not incorporate any supportive services for the SMI population.

Several counties are implementing innovative programs to address the lack of affordable housing, as well as link consumers to needed services and assist consumers to live more independently in the community. However, there are no programs that directly increase the stock of culturally and linguistically responsive residential care facilities. Additionally, there is no readily available information on how to establish a culturally and linguistically responsive residential care facility, as a review for literature on this topic reveals no certain criteria or attributes have been established to define and support cultural and linguistic responsiveness in residential care settings. Therefore, MCBH has identified a need and an opportunity to incubate and train property owners to open and operate residential care facilities that are culturally and linguistically responsive for consumers and are financially viable for owners.

The Proposed Project

Monterey County Behavioral Health (MCBH) is proposing a two-phased Innovation project that will seek out existing, motivated residential care facility operators interested in providing more culturally and linguistically responsive services, as well as engage new property owners interested in establishing new culturally and linguistically responsive residential care facilities. As a result of this project, MCBH will increase the availability of culturally and linguistically appropriate

housing for the adult SMI population by repurposing residential and commercial properties to support residential care clients. In addition, existing residential care facilities that are struggling to operate and provide adequate services will be rejuvenated. The two-phases of this Innovation project are:

> **Phase I: Research and Planning** – The training and supports needed to equip property owners to operate a licensed or unlicensed residential care facility that is culturally and linguistically responsive to the local SMI population will be identified and developed.
>
> **Phase II: Implementation** – Consultants, including peer providers, will educate and train property owners about how to integrate more culturally and linguistically responsive services into their facility. Property owners will also receive training and technical assistance related to operating a small business. Once established, eligible MCBH ASOC consumers will be referred to these facilities while continuing to receive services through MCBH to achieve their Reaching Recovery® goals.

MCBH is currently seeking approval for the use of Innovation funds for Phase I only. Phase I will include in-depth research to better understand the housing challenges facing people with SMI within specific cultural groups in our community, as well as the challenges facing residential care facility operators. Results from the Phase I research will be used to develop the infrastructure and materials to support participating property owners in operating successful culturally and linguistically responsive residential care facilities. MCBH will utilize one or more consultants, including peer providers, with expertise in residential care facilities, cultural competency, and small business operations, to identify and develop the information and materials below by answering the corresponding questions:

- Attributes of a culturally and linguistically responsive residential care facility for the target population
    - What are the staffing requirements (how many bilingual/bicultural staff, etc.)?
    - How can programming respond to specific cultural and linguistic needs of various populations?
    - What cultural and linguistic attributes are missing in existing facilities?
    - What information is available through the California Reducing Disparities Project (CRDP) that may help identify these attributes?
- Policies, protocols, and trainings for providing culturally and linguistically responsive residential care facility services to people with SMI in specific population groups.
    - What evidence-based approaches, including those identified by the CRDP or other studies, can be used to respond to the cultural and linguistic needs of specific population groups including Latinos, African Americans, Asian Americans, LGTBQ, Veterans, formerly institutionalized, formerly incarcerated, etc.?
- Marketing and recruitment strategy to enroll qualifying property owners.
    - What is the current housing inventory for individuals with SMI relying on SSI?
    - Are there enough interested and willing property owners in Monterey County to enroll in this project and offer a residential care service, to warrant the pursuit of Innovation funds for Phase II?
        - Where are these properties located?
        - Why are owners interested? What is their cultural background and capacity?
        - What incentives are available to create interest? How will this be communicated?
        - How can MCBH advertise and reach interested property owners?
- Establishing and/or operating a licensed or unlicensed residential care facility manual.
    - What are the requirements, barriers, and solutions to the barriers for implementation, including:
        - Planning and building ordinances

        - Health and human safety
        - Security
        - Disability rights
        - Licensure requirements
        - Insurance requirements
        - Personnel management
        - Supply and logistics
        - Provision of care
        - Financial (both start-up and ongoing)
        - Addressing potential "not in my backyard" issues from neighbors
- Policies, protocols and trainings relevant to operating a residential care facility and promoting interagency collaboration in the provision of referrals and services.
    - What supports are needed related to the consumer's ability to pay or otherwise support the property owner to receive reimbursement for the provision of services?
        - How will clients know where and how to access SSI?
        - How will property owners be reimbursed or receive payment?
    - What are the eligibility criteria for consumers and what is the referral process?
        - How can the process ensure consumers are matched to an appropriate residential care facility?

The completion of Phase I, and the evaluation of lessons learned, will determine if and how Phase II can be feasible, community informed and efficient. Pending the future application and approval for Phase II, for the implementation of Phase II, MCBH will engage with an administrative consultant or entity that will provide project management and coordination services for the residential care facilities associated with this project. This consultant will function as the primary liaison between MCBH and the participating residential care facilities, including in the coordination and communication of consumer referrals and grievances. This consultant will also be responsible for providing and/or coordinating the delivery of technical assistance programs and operational trainings that were developed as part of Phase I. Consumers placed in these facilities will continue to receive mental health services through MCBH.

The Innovative Component

The proposed Innovation project will attempt to change an existing practice in mental health by promoting interagency and community collaboration related to mental health service supports and outcomes. Specifically, this Innovation project seeks to establish culturally and linguistically responsive housing options by engaging with local property owners and peer providers, thereby increasing the overall housing stock available for adults experiencing SMI who are homeless or at risk of homelessness.

Currently, licensed and unlicensed residential care facilities do not meet the cultural and linguistic needs of our diverse community. Existing residential care facilities are facing significant fiscal and operational challenges, and the number of available beds for those experiencing SMI is declining. The proposed Innovation project seeks to fill a void by incubating residential care facilities in Monterey County through a model that is more culturally and linguistically responsive for consumers to support their recovery goals, and more sustainable for operators. Through this Innovation project, MCBH seeks to incentivize and utilize peer providers and consultants to educate property owners who are already integrated in the community to leverage their property to help those in need while simultaneously generating a sustainable income for themselves.

Population of Focus

The population of focus for this project is the SMI population in Monterey County that is at least 18 years of age and is homeless or at risk of homelessness. Particular focus is granted to individuals currently enrolled in MCBH's Adult System of Care (ASOC) services.

Learning Goals / Project Aims

Phase I of this Innovation project aims to incentivize property owners to increase the stock of culturally and linguistically responsive housing options for the SMI population by answering the following questions:

1. What are the attributes of a culturally and linguistically responsive residential care facility that serves the SMI population; and what are the specific needs for culturally and linguistically responsive residential care facilities in Monterey County?
2. What barriers are preventing residential care facilities from being developed and remaining sustainable?
3. What are the required supports to assist property owners who are already culturally and linguistically integrated in the community, who are interested and can be incentivized to turn their home or property into a residential care facility?
4. What support is needed to ensure these residential care facilities are financially sustainable for property owners?
5. What materials and technical assistance will be required to support implementation in Phase II?

Future learning goals (anticipated) to be included and evaluated during Phase II include:

6. Are consumers more likely to retain housing placements when placed in culturally and linguistically appropriate housing?
7. Do consumers move from more intensive levels of services to less intensive levels of services on the Reaching Recovery® model when placed in a culturally and linguistically responsive residential care facility?

Evaluation or Learning Plan

Current ASOC consumers and staff will be surveyed to determine the attributes of and specific needs for culturally and linguistically responsive residential care facilities that serve the SMI population in Monterey County.

To evaluate efficacy of this residential care facility model, a review will be performed of the marketing and outreach activities to determine existing property owners' interest and readiness to open and operate culturally and linguistically responsive residential care facilities in Monterey County. After identifying participating property owners, a review will be performed on their capital facility and financial needs to cover operating costs. Additionally, a qualitative report will be generated that identifies barriers to owning and operating licensed and unlicensed residential care facilities for the SMI population.

Cultural and linguistic responsiveness of residential care facilities in this project will be evaluated by surveying consumers about their experience and satisfaction as it relates to the cultural and linguistic responsiveness of the facility to their needs.

Quantitative evaluation methodologies will be used to evaluate consumer outcomes. Avatar Electronic Health Records and the Reaching Recovery® tool will measure consumer improvement by measuring homeless days, incarceration,

emergency room visits, psychiatric hospitalizations, substance use, overall functioning including symptom management, interest in education, work, participation in services, as well as life satisfaction of consumers placed in these residential care facilities.

Section 3: Additional Information for Regulatory Requirements

Community Program Planning Process

This Innovation Plan was developed during the Community Program Planning Process for the MCBH Mental Health Services Act (MHSA) FY 2021-23 Three-year Program and Expenditure Plan. Ten Community Engagement Sessions were held between October 2019 to December 2019 throughout Monterey County, where a total of 181 community stakeholders participated. Three themes emerged across the 10 Community Engagement Sessions, which helped originate and form this Innovation Plan to incubate culturally and linguistically responsive residential care facilities. The 3 themes include a desire by stakeholders for MCBH:

- Deepen and Expand Culturally Responsive, Trauma-informed Staffing, Approaches & Practices
- Expand In-place, Embedded Culturally Responsive Care
- Foster Policy, Systems Change

Participants advocated for staffing, approaches, and programs that honored people's individuality and cultural backgrounds. Participants reported services that work well and are effective, do not take a one-size-fits-all approach; rather, they are designed to respond to and embrace people's various cultures and experiences, whether it be racial and ethnic backgrounds, languages used, experiences of trauma, other social identities and experiences. Participants advocated for continued implementation to expand effective culturally responsive approaches and practices to better address the assets, interests, needs, and realities of Monterey County residents, especially those relevant to Monterey County residents with historically underrepresented, marginalized, and vulnerable identities. Addressing the homeless SMI population and their multitude of needs was included here as a population of focus, along with the emphasis to expand Spanish and English bi-lingual services in addition to indigenous languages spoken (e.g., Triqui), Tagalog, and other languages reflective of the diverse population in Monterey County.

Participants also advocated for expanded access and quality care throughout their local communities. Although stand-alone mental health facilities would be welcomed assets, participants noted resources invested in leveraging social trust capital of key influencers and existing locations to expedite increased access to mental healthcare could serve more people quicker and more cost-effectively than would major capital projects to expand services. This includes leveraging community assets for housing, and relying on and partnering with cultural leaders, experts and organizations, to generate interest among both potential consumers and property owners associated with this Innovation Plan.

Additionally, participants consistently noted the need for increased awareness, communication, and engagement at all levels between stakeholders, consumers and providers, to support policy-makers in making progress towards systems change and policy related to the current housing crisis and challenges facing residential care facilities. Stakeholders advocated for MCBH to work to change policy to allow for insurance reimbursement, billing when services are delivered

beyond traditional facilities and "in-place", and improve cross-organizational collaboration and coordination between MCBH, other public agencies, and external entities (for example, primary care doctors, emergency rooms, community-based organizations, housing authorities, service providers, etc.). Taken together, the proposed Innovation Plan to incubate culturally and linguistically responsive residential care facilities in Monterey County has been constructed to be a promising practice for serving a primary population of focus, and meeting the community needs identified by participating stakeholders. As such, the concepts and budget put forward in this Innovation Plan were included in the MCBH FY2021-23 MHSA Three-Year Program and Expenditure Plan that was approved by stakeholders, the Monterey County Behavioral Health Commission, and Monterey County Board of Supervisors.

MHSA General Standards

This INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards below:

Community Collaboration

Community collaboration will be central to Phase I of this INN project, whereby research and design activities will occur in collaboration with community stakeholders to create the implementation plan for Phase II. During Phase I, community partners and stakeholders will be engaged in two ways. First, the community will be engaged during the discovery process to identify detailed cultural and linguistic needs of the local SMI population that is homeless and at-risk of homelessness, barriers to housing and care, and potential remedies. This discovery process will also engage with the community to identify the available supply of interested property owners, potential barriers to implementation such as NIMBYism, as well as review fiscal and logistical constraints experienced by existing residential care facilities operators.

Cultural Competency

Cultural competency is a critical component to this project, as the goal is to incubate a supply of culturally and linguistically responsive residential care facilities. Cultural and linguistic considerations will be taken into account during the research and design activities of Phase I, and will also be central to implementation and evaluation efforts in the eventual Phase II.

Client-Driven

This project will be client-driven as participation will be voluntary, and client mental health plans will be self-determined. Additionally, the evaluation efforts will be client-driven whereby client mental health outcomes will be a primary measure of effectiveness of this project.

Family-Driven

This project will encourage participation and feedback from family members of mental health consumers and project participants throughout proposed Phase I activities, and eventual Phase II implementation. In as much as this project will be client driven and support community collaboration, family members and family functioning will be considered during planning and evaluation activities.

Wellness, Recovery and Resilience-Focused

Supporting the wellness, recovery and resilience of clients is the end goal of this program, and measuring for these factors is a significant part of the evaluation efforts of this project. This project identifies housing insecurity as a serious problem to be addressed to help clients establish path towards recovery and stability. Clients participating in the program will have their unique wellness, recovery and resiliency goals affiliated with the Reaching Recovery® model. It is the intention of this project to demonstrate that housing stability, particularly when housing environments are culturally and linguistically responsive, will correlate to improve wellness, recovery and resiliency outcomes.

Integrated Service Experience for Clients and Families

Activities supported by the Innovation Project will be integrated into each of the MCBH systems of care so that individuals and families will have a seamless transition into services and programs. Clients in the MCBH Adult System of Care will be the initial population of focus to be referred into residential care facilities that are incubated as part of this project.

Cultural Competence and Stakeholder Involvement in Evaluation

Cultural competency and stakeholder involvement will be at the foundation of evaluation for this project. Culturally competency will be included wherein the effectiveness of the culturally and linguistically responsive approaches employed in Phase II will be assessed. Community stakeholders will be included in both the design and review of evaluation goals and measures. Specifically, stakeholders will contribute to the definition of cultural and linguistic needs, and identification of appropriate responses to the needs. Evaluation measures will be informed by this stakeholder contribution.

Innovation Project Sustainability and Continuity of Service

If this project must be terminated prior to the conclusion of the timeline as stated in this plan, continuity of service to consumers being provided mental health treatment services will be funded through sources such as MHSA and Realignment match funds for Federal Financial Participation reimbursement, and Supplemental Security Income and Disability Insurance for housing.

Communication and Dissemination Plan

Community stakeholders will be engaged during Phase I through the preferred approach determined by the selected vendor(s). MCBH will supports communication efforts by leveraging existing community stakeholder distribution lists, community based provider relationships and MCBH staff during related outreach efforts.

Five keywords the MHSOAC may associate with this Innovation project to facilitate a database search include: Housing, Homelessness, Residential Care Facility, Supported Living Environments, Cultural and Linguistic Responsiveness.

Contracting

To implement this Innovation Plan, MCBH intends on contracting with one or more vendors. MCBH staff will provide administration oversight of project implementation and evaluation.

Timeline

The total timeframe (duration) requested to complete both Phase I and Phase II of this Innovation project shall not exceed 5 years. The timeline for key phases / deliverables is as follows:

Phase 1 (2 years):

- [3-6 months] Acquire consultant/vendor(s) through RFP
- [12-18 months] Consultant/vendor(s) to evaluate opportunities and barriers for implementation, with the intended result of creating an actionable implementation plan (i.e. Phase II plan) for incubating cultural and linguistically responsive residential care facilities to mitigate housing instability concerns among the SMI population and positively impact mental health outcomes in their path to wellness. Activities to be performed as part of Phase I will be in service of Learning Goals 1-5, and will be generally inclusive of:
    - Identifying cultural/linguistic needs of the population of focus, and identifying/informing corresponding tools and trainings for residential care facility providers to adequately respond to cultural/linguistic needs of the population of focus that may improve retention and outcomes
    - Investigating known and currently unknown challenges being experienced by residential care facility operators in Monterey County and California that negatively impact their sustainability, and identifying corresponding solutions via technical assistance, training and/or policy change.
    - Identifying and recruiting interested property owners
    - Planning with MCBH to establish a strategy for providing client placements and care coordination

Phase 2, Pending future approval and structure/outcomes established in Phase 1 (3 years):

- Enter into agreement with participating properties (directly or indirectly)
- Support client placements and provide mental health services
- Provide necessary trainings to support cultural/linguistic responsiveness
- Conduct process and outcome evaluations

Section 4: INN Project Budget and Source of Expenditures

Budget Narrative

Please note the following budget description applies to Phase I only.

Personnel Costs: MCBH requests a total budget of $448,290 to support personnel costs through the maximum 24-month duration of Phase I. The roles and responsibilities of personnel to be supported include:

Job Title	Responsibilities	FTE	Total Annual Cost
Management Analyst II	Function as Innovation Coordinator to provide/support project management, service coordination, communications and outreach, vendor procurement, evaluation and reporting activities.	0.125	$23,815
Public Health Epidemiologist I	Participate and collaborate with vendor(s) and stakeholders in Phase I to develop evaluation plan for Phase II implementation.	0.125	$21,060
Behavioral Health Services Manager II	Monitor and approve vendor deliverables, and provide technical assistance on matters such as service coordination, as needed.	0.125	$28,662
Behavioral Health Aide	Function as peer specialists to ensure Phase I and Phase II activities will be culturally competent and consumer driven.	1.25	$150,607

Indirect costs associated with these positions are calculated at 13.86% of salary.

Consultant Costs / Contracts: Consultant(s) will be utilized to perform and support the planning and reporting activities associated with Phase I. Specifically, MCBH will be seek consultant services to research and design plans to supply a compelling and actionable Phase II implementation plan. Consultant(s) will work in collaboration with MCBH and community stakeholders. MCBH will be seeking, through appropriate procurement protocols, consultant services of subject matter experts in residential care facility certification and management, supportive housing services, cultural and linguistic competency, marketing and communications. The total budget request to support consultant costs throughout the 24-month term of Phase I is $343,842.

Use of Reversion Funds: MCBH will prioritize spending of all previously unspent Innovation funds allocated to Monterey County that may be subject to reversion.

Budget Tables

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*				
EXPENDITURES				
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**TOTAL**
1.	Salaries	$193,078	$193,078	$386,155
2.	Direct Costs			
3.	Indirect Costs	$31,066	$31,066	$62,133
4.	Total Personnel Costs	**$224,144**	**$224,144**	**$448,288**
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**TOTAL**
5.	Direct Costs			
6.	Indirect Costs			
7.	Total Operating Costs			
NON RECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**TOTAL**
8.				
9.				
10.	Total Non-recurring costs			
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 21/22**	**FY 22/23**	**TOTAL**
11.	Direct Costs	$171,921	$171,921	$343,842
12.	Indirect Costs			
13.	Total Consultant Costs	$171,921	$171,921	$343,842

OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**TOTAL**
14.				
15.				
16.	Total Other Expenditures			
BUDGET TOTALS				
Personnel (line 1)		$193,078	$193,078	$386,155
Direct Costs (add lines 2, 5 and 11 from above)		$171,921	$171,921	$343,842
Indirect Costs (add lines 3, 6 and 12 from above)		$31,066	$31,066	$62,133
Non-recurring costs (line 10)		$0	$0	$0
Other Expenditures (line 16)		$0	$0	$0
TOTAL INNOVATION BUDGET		**$396,065**	**$396,065**	**$792,130**

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)				
ADMINISTRATION:				
A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**TOTAL**
1.	Innovative MHSA Funds	$290,764	$290,764	$581,528
2.	Federal Financial Participation			
3.	1991 Realignment			
4.	Behavioral Health Subaccount			
5.	Other funding*			
6.	**Total Proposed Administration**	**$290,764**	**$290,764**	**$581,528**

EVALUATION:				
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**TOTAL**
1.	Innovative MHSA Funds	$105,301	$105,301	$210,602
2.	Federal Financial Participation			
3.	1991 Realignment			
4.	Behavioral Health Subaccount			
5.	Other funding*			
6.	**Total Proposed Evaluation**	**$105,301**	**$105,301**	**$210,602**
TOTAL:				
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**TOTAL**
1.	Innovative MHSA Funds	$396,065	$396,065	$792,130
2.	Federal Financial Participation			
3.	1991 Realignment			
4.	Behavioral Health Subaccount			
5.	Other funding*			
6.	**Total Proposed Expenditures**	**$396,065**	**$396,065**	**$792,130**
*If "Other funding" is included, please explain.				

References

California Behavioral Health Planning Council. (2018). *Adult Residential Care Facilities: Highlighting the critical need for adult residential facilities for adults with serious mental illness in California.* https://www.dhcs.ca.gov/services/MH/Documents/Legislation-Committee/2018-ARF-Final.pdf